New Client Information Form (Adults)

Client Name: ___________________________________ **Date of Birth:** ____________ **Age:** ______

Legal Sex: ☐ Male ☐ Female ☐ Non-Binary ☐ Not Specified

Gender: ☐ Male ☐ Female ☐ Other (please specify): ___________________________________

Preferred Pronouns: __________________________________

Address: ____
(street) (city) (state) (zip)

Client Employer/School: ____

Client Cell: ___________________ OK to leave a message? ☐ Yes ☐ No

Alternate Phone: ___________________ OK to leave a message? ☐ Yes ☐ No

Client Email: ____ OK to email? ☐ Yes ☐ No

Primary Care Physician & City: ____

Client's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How did you hear about our practice? ____

May we thank the referral source? ☐ Yes ☐ No

CLINICAL INFORMATION:

Please briefly describe your reason for seeking therapy: ___________________________________

____

____

Have you ever been in therapy or received any type of counseling before? ☐ Yes ☐ No

If yes, please list when, where and with whom you received services and the reason:

____

____

Are there any safety concerns (past or present)? (This may include, but is not limited to, aggressive behavior toward self or others or thoughts of self-harm or suicide) ☐ Yes ☐ No

If yes, please describe: ____

____

Please list any major illnesses and/or hospitalizations you've had, if applicable, with approximate dates:

____

____

Please list any medications you are currently taking (name of medication and dosage, including OTC medication):

____

____

____

Do you have a history of any substance use issues? ☐ Yes ☐ No

If yes, please describe: ____

____

Family History of substance use issues (please list/describe immediate or extended family):

____

____

Family History of mental health issues (please list/describe immediate or extended family):

____

____

If there is any other additional information that that you would like to share, please include it below:

____

____

____