

NEW CLIENT INFORMATION-ADULT

Client Information

Date: _____ Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: ____ - ____ - ____ Gender: Male [] Female [] Last 4 of Social: _____ Age: _____

Marital Status: [] Single; [] Married; [] Divorced; [] Widowed Ethnicity/Race: _____

Spouse Name: _____ Spouse Phone: _____

Email: _____ Occupation: _____

Cell: _____ Home: _____ Work: _____

Preferred Method of Contact: _____ May we leave confidential messages? Yes [] No []

Referred By: _____ Phone: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to Client: _____

Family History

Do you have children? _____ If so, how many? _____ Check all that apply for your family history:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Anxiety Disorders |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Trauma History |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Suicide Attempts |

Additional Information

Are you being required to attend therapy due to a court order? _____

Were you advised to seek treatment by a doctor? _____

Symptom Assessment

Check all the symptoms that you are experiencing:

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Extreme Sadness | <input type="checkbox"/> Trouble Concentrating |
| <input type="checkbox"/> Change in eating habits | <input type="checkbox"/> Poor job performance | <input type="checkbox"/> Self-esteem issues |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Anger issues | <input type="checkbox"/> Self-harm |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unable to sleep |
| <input type="checkbox"/> Isolation/withdrawal | <input type="checkbox"/> Physical pain | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Feelings of panic | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Substance use |
| <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Acts of violence | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Suicide Attempts |

Health and Social History

Primary Care Physician: _____ Phone: _____

Have you ever been diagnosed with a mental disorder? Yes No Diagnoses: _____

By Whom? _____

Current Medications:

Medication	Dosage/Frequency	Effective Date	Purpose

Have you ever been hospitalized for psychological reasons? Yes No

Hospital	Month/Year	Reasons

Have you contemplated suicide? Yes No When? _____

Have you contemplated homicide? Yes No When? _____ Who? _____

Have you received previous counseling or psychotherapy? Yes No

~Progressing on Purpose Counseling, PLLC~

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Health and Social History Continued

If so, by whom: _____ When? _____

How long? _____ Phone: _____

Please rate the following (1= poor; 5= excellent)

Work ____ Family ____ Peer Relationships ____ Marriage/Significant Other ____ Overall Happiness ____

In the past week, have you experienced (Check all that apply):

Anger Fear High Energy Sadness Tension Concerns about body

Added Information

Please complete the following statements:

I am aware that... _____

Six months from now... _____

I am here today because... _____

Information You Want The Therapist To Know

I testify that to the best of my knowledge the information that I have provided is accurate and true. I understand that falsifying information is unlawful and punishable. I understand that my therapist may share my information with other professionals with the intent to consult for treatment purposes. I also understand that my information will be safeguarded for legal and confidentiality reasons. I have been able to ask all clarifying questions to ensure my understanding going forward.

Client(s) Name (Please Print)

Client(s) Signature

Date

By checking this box, you acknowledge and accept the signature above as your own.