~Progressing on Purpose Counseling, PLLC~
8300 Cypress Creek Parkway Ste 472 * Houston, Texas 77070
Office: 281-671-6804 * Business Cell: 713-302-1030 * Fax: 281-671-6601

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:**

☐ **Depression** ☐ **Bipolar Disorder** ☐ **Anxiety Disorders**

☐ **Panic Attacks** ☐ **Schizophrenia** ☐ **Substance Abuse**

☐ **Eating Disorder** ☐ **Learning Disabilities** ☐ **Trauma History**

☐ **Homicide** ☐ **Hospitalization** ☐ **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? _____

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Symptom Assessment

Check all the symptoms that you are experiencing:

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

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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 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.**