

**NEW CLIENT INFORMATION SHEET**

Today's date: \_\_\_\_\_

**A. Identification**

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/cell phone: \_\_\_\_\_ Permission to leave voicemail? \_\_\_\_\_

E-mail: \_\_\_\_\_

\* By including your email address, you are granting permission that I communicate logistics and send forms by email, as needed. Please note that email is not a secure form of communication.

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

**B. Referral:** How did you learn about my services? Did someone give you my name?

Name or resource: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Approval to leave voicemail? \_\_\_\_\_

Person in case of an emergency that I'm authorized to contact (name, relationship and number) \_\_\_\_\_

**C. Personal Identity** 1. **Ethnicity/national origin:** \_\_\_\_\_ **Race:** \_\_\_\_\_

2. **Gender/sex :** \_\_\_\_\_ 3. **Spiritual or religious denomination/affiliation** (if any): \_\_\_\_\_

How active are you ?  None  Some  Active How important are spiritual concerns in your life? \_\_\_\_\_

4. **Other way you identify yourself and consider important:**

\_\_\_\_\_

**D. Your current employer:** \_\_\_\_\_

**E. Your education and training:** What level of education have you completed? \_\_\_\_\_

Any special education classes or learning differences? \_\_\_\_\_

Any adjustment issues or difficulties in school? \_\_\_\_\_

Are you interested in pursuing further education? \_\_\_\_\_

*This is a strictly confidential patient medical record. Redisclosure or transfer is prohibited by law.*

**F. Family-of-origin and Chosen Family History:**

Please give brief information about important family members: stepparents, siblings, or others

Relative	Name	Current age	Illnesses	Mental Health Issues	Education & Occupation	Other important information?
Mother						
Father						

**G. What is the primary reason you are seeking counseling now ?** \_\_\_\_\_

\_\_\_\_\_

Have you ever had any thoughts of harming yourself or another person? \_\_\_\_\_  
 If so, when? \_\_\_\_\_

When did you first notice the issue/problem that brings you to counseling? (please provide a date if possible) \_\_\_\_\_

**H. Current medications:**      Dosage:              Taken for:              Taken Since:

\_\_\_\_\_

\_\_\_\_\_

**I. Significant medical history:** \_\_\_\_\_

Have you ever been in counseling before? If so, when and for how long?  
 \_\_\_\_\_

What was your reason for discontinuing counseling?  
 \_\_\_\_\_

**What do you hope to accomplish by coming to counseling?**  
 \_\_\_\_\_

**Any other information you think I should know before we begin our work together?** \_\_\_\_\_