New Client Information

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: ____ Date__________________

Name of parent/guardian (if you are a minor): ____

Local Address: ____

____

(Street info, City, State and Zip)

Home Phone: ______________________ May we leave a msg? □Yes □No

Cell/Other Phone: __________________ May we leave a msg? □Yes □No

E-mail: ___________________________________ May we email you? □Yes □No

May we contact you by mail? □Yes □No

May we contact you by phone? □Yes □No Text? □Yes □No

Please be aware that email and phone contact may not be confidential

Birth Date: ______ /______ /______ Age: ________ Gender: __________________

Marital Status:

□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Children's Names and Ages: ____

____

Your Education Information – List any degrees or specialized training you have received:

____

Your Occupation: __________________ Employer: ___________________________________

If unemployed, list last employer, occupation and dates of employment:____

Contact Person in Case of Emergency: ____

Relationship: ____________________ Phone: ____

How did you hear about Hope Counseling Services, LLC? ______________________________

Referred by: ____________________________May we thank your referral source? □No □Yes

Have you previously been involved in counseling or therapy? □No □Yes

Previous therapist's name____

Do you want me to contact them: □No □Yes Phone: _________________________________

What are you hoping to accomplish through counseling: _______________________________

____

____

____

Do you want to use health insurance to help pay for counseling services? □No □Yes
Company and policy number ____
____
Primary Care Physician's Name: ____
Address: ____________________________________ Phone: ________________________
City: __________________State: ___ Zip: _______ Date of Last Physical: _______________

Have you participated in any type of addictions program? □No □Yes –If yes, please list name and location: __________________________________ ______________________________

List all prescribed and over the counter medications you presently take: ___________________
____

If no, have you been previously prescribed psychiatric medication? □No □Yes, please list:
____

Are you currently receiving psychiatric services, counseling or therapy elsewhere? □No □Yes
Name and Contact Information____
__

Have you experienced abuse in your childhood? ____Sexual ____Physical ___Mental/Emotional

Have you been the victim of domestic violence or a violent crime as an adult? ❑ No ❑ Yes

Have you experienced a Traumatic Event? Explain ____________________________________

HEALTH INFORMATION

1. Circle Your Present physical health? Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, illness, headaches, hypertension, diabetes, etc.): ____
____
____

3. Are you having any problems with your sleep habits? □ No □ Yes
If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other ____

4. How many times per week do you exercise? _________How long each time? _____________

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting
Have you experienced significant weight change in the last 2 months? □ No □ Yes

6. How often do you drink alcohol per week? _______________________________________
In a typical month, how often do you have 4 or more drinks in a 24-hour period? ____________

7. How often do you use recreational drugs? □ Daily □ Weekly □ Monthly □ Rarely □ Never
List Recreational Drugs and method of use _______________________________________

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never
   Have you had them in the past? ______________ When: ________________________________
   □ Frequently □ Sometimes □ Rarely □ Never

Are you currently in a romantic relationship? □ No □ Yes If yes, how long? _______________

In the last year, have you experienced any significant life changes or stressors? Briefly explain:

____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

If yes, what is your religious affiliation, faith or church? _________________________________

Do you consider yourself to be spiritual? □ No □ Yes

CIRCLE ALL SYMPTOMS YOU HAVE BEEN EXPERIENCING

Afraid
Agitated
Angry
Anxious
Arm or Hand Pain
Ashamed
Backache
Blackout Spells
Blurred Eyesight
Bored
Careless
Chest Pain
Chills
Constipation
Crying Spells
Daydreams
Diarrhea
Dizziness
Drowsiness
Dry Mouth
Excitable
Exhaustion
Fainting
Fatigue
Fearful
Fever
Flashbacks
Foggy
Gloomy
Grieving
Guilty
Headache
High Blood Pressure
Hyper
Insecure
Irritable
Itching
Lethargic
Lonely
Loss of Appetite
Loss of Consciousness
Loss of Energy
Loss of interest in Sex
Loss of interest in Life
Moody
Muscle Cramps
Nausea or Vomiting
Neck pain
Nervousness
Nightmares
Numbness
Panic
Poor Memory
Rapid Speech
Recent medication changes
Restlessness
Ringing in ears
Sad
Self-conscious
Shaky
Stomach ache
Stressed Out
Stubborn
Suspicious
Sweating
Tense
Tired
Trembling
Unable to Concentrate
Unable to Control thoughts
Unable to Have Fun
Unable to Make Decisions
Unable to Think Clearly
Unable to Work
Unexplained Loss of Time
Unhappy
Unsafe
Weakness
Weight loss
Weight gain
Worried
Worthless
____
____
____

Signature: _____________ ____________________ **Date**: _______________