Sabeen Shaiq, LCSW
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New Client Information Form

Date of Initial Appointment: _____ /_____ /_____ Availability_____
Starting fee:_____ Fee Arrangements:_____

Name _____

Name of parent/guardian (if minor)_____

Address _____

City, Zip _____

Birth date _____ /_____ /_____ Age: _____

Phone _____ May I leave a message? ❒ No ❒ Yes

E-mail* _____ May I email you? ❒ No ❒ Yes

Relationship Status:_____ # of Children_____ Ages:_____

Current Work/School:_____ Ethnicity(ies): _____
❑ Declined to state

Referred by:
_____

Reason for Therapy:
_____

_____

Previous Treatment:_____ Medications:_____
Depression/Suicide:_____ Drug/Alcohol:_____

Person I may contact in an emergency:
Name: _____

Phone: (Cell) _____ (Home/Work)_____

Notes:
_____

_____

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New Client Assessment Form

Please provide the following information for my records. If some of this information feels too personal to share right at the beginning of our work together, you can leave those questions blank. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself fifteen minutes prior to your appointment to complete the form in the office.

Describe any medical care or treatment you are currently receiving:

_____

_____

Have you ever received any psychiatric services, professional counseling or psychotherapy?
❒ No ❒ Yes

How was that for you?
_____

Have you ever taken any prescribed psychiatric medication (antidepressants or others)?
❒ No ❒ Yes If yes, please list:
_____

HEALTH INFORMATION

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

   _____

2. Are you having any problems with your sleep habits? ❒ No ❒ Yes

   If yes, check where appropriate: ❒ Sleeping too little ❒ Sleeping too much
   ❒ Poor sleep quality ❒ Disturbing dreams
   ❒ Other

3. Are you having difficulty with appetite or eating habits? ❒ No ❒ Yes

   If yes, check where appropriate: ❒ Eating less ❒ Eating more
   ❒ Binging ❒ Restricting ❒ Other

4. Do you regularly use alcohol? ❒ No ❒ Yes

   How often?❒ Daily (how many drinks per day? _____) ❒ Weekly (how many nights per week? _____)
   ❒ Monthly ❒ Rarely ❒ Never

5. Do you engage in recreational drug use? ❒ No ❒ Yes

   How often?❒ Daily (How often per day? _____) ❒ Weekly (How many nights per week? _____)
   ❒ Monthly ❒ Rarely ❒ Never

6. Have you ever had suicidal thoughts?
   _____

7. Have you ever experienced:

Extreme depressed mood	❒ No	❒ Yes
Wild mood swings	❒ No	❒ Yes
Rapid speech	❒ No	❒ Yes
Extreme anxiety	❒ No	❒ Yes
Panic attacks	❒ No	❒ Yes
Phobias	❒ No	❒ Yes
Sleep disturbances	❒ No	❒ Yes
Hallucinations	❒ No	❒ Yes
Unexplained losses of time	❒ No	❒ Yes
Unexplained memory lapses	❒ No	❒ Yes
Alcohol/Substance abuse	❒ No	❒ Yes
Frequent body complaints	❒ No	❒ Yes
Eating Disorder	❒ No	❒ Yes
Body image problems	❒ No	❒ Yes
Repetitive thoughts (e.g. obsessions)	❒ No	❒ Yes
Repetitive behaviors (e.g. frequent checking, hand washing, etc.)	❒ No	❒ Yes
Homicidal thoughts	❒ No	❒ Yes
Suicide attempt(s)	❒ No	❒ Yes

FAMILY HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? Check any that apply and list family member, e.g. sibling, parent, uncle, etc.:

Difficulty	Family Member
Depression ❒ No ❒ Yes	
Bipolar Disorder ❒ No ❒ Yes	
Anxiety Disorders ❒ No ❒ Yes	

Panic Attacks ❒ No ❒ Yes

Schizophrenia ❒ No ❒ Yes

Alcohol/Substance Abuse ❒ No ❒ Yes

Eating Disorders ❒ No ❒ Yes

Learning Disabilities ❒ No ❒ Yes

Trauma History ❒ No ❒ Yes

Suicide Attempts ❒ No ❒ Yes

Are you currently in an intimate relationship? ❒ No ❒ Yes

If yes, how long have you been in this relationship?

_____

How would you describe your relationship?

_____

ASSESSMENT INFORMATION

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

_____

_____

_____

Are you currently employed, how do you feel about your work/place of employment?

_____

Please list any work-related stressors that feel important to share:

_____

_____

What are your goals for therapy?

_____

_____

_____

Briefly describe what brought you here:

_____

_____

_____

When have you felt better or as though what brought you here disappeared?

_____

_____

_____

What do you think helped?

_____

_____

_____

When has what brought you here been especially bad?

_____

_____

_____

What made it worse?

_____

_____

_____

Who plays a major role in making things feel more challenging or helping you cope? _____

_____

_____

What else do you believe could be important or helpful for me to know at this time? _____

_____

_____

_____

_____

_____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0 1 2 3 4 5 6 7 8 9 10
No Minimal Concern Moderate Concern Extreme Concern

_____ Anger

_____ Religious/spiritual

_____ Depression

_____ Sex/intimacy

_____ Education

_____ Thoughts of suicide

_____ Eating or body image

_____ Trouble making decisions

_____ Social relationships/friends

_____ Partnership/dating/relationship

_____ Use of other drugs

_____ Physical/health

_____ Work/employment

_____ Worry

_____ Relationship(s) with family

_____ Fearfulness

_____ Unhappy most of the time

_____ Nervousness

_____ Use of alcohol

_____ Gender identity/transition

_____Sexual orientation

_____ Finances

_____ Loved one's drug/alcohol use

_____ Relationship(s) with (a) parent(s)

_____ Other (specify)

_____