

### New Client Information Form

Date of Initial Appointment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Availability \_\_\_\_\_

Standard fee: \_\_\$150/ 50 minutes \_\_\_\_\_ 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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:

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

How was that for you?

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

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### HEALTH INFORMATION

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

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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?

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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

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Panic Attacks  No  Yes

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Schizophrenia  No  Yes

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Alcohol/Substance Abuse  No  Yes

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Eating Disorders  No  Yes

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Learning Disabilities  No  Yes

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Trauma History  No  Yes

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Suicide Attempts  No  Yes

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Are you currently in an intimate relationship?  No  Yes

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

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How would you describe your relationship?

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### **ASSESSMENT INFORMATION**

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

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

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

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What are your goals for therapy?

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Briefly describe what brought you here:

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

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What do you think helped?

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When has what brought you here been especially bad?

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What made it worse?

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

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

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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                           | _____ Fearfulness                        |
| _____ Religious/spiritual             | _____ Unhappy most of the time           |
| _____ Depression                      | _____ Nervousness                        |
| _____ Sex/intimacy                    | _____ Use of alcohol                     |
| _____ Education                       | _____ Gender identity/transition         |
| _____ Thoughts of suicide             | _____ Sexual orientation                 |
| _____ Eating or body image            | _____ Finances                           |
| _____ Trouble making decisions        | _____ Loved one's drug/alcohol use       |
| _____ Social relationships/friends    | _____ Relationship(s) with (a) parent(s) |
| _____ Partnership/dating/relationship | _____ Other (specify)                    |
| _____ Use of other drugs              | _____                                    |
| _____ Physical/health                 |  |
| _____ Work/employment                 |  |
| _____ Worry                           |  |
| _____ Relationship(s) with family     |  |

PLEASE COMPLETE THE FOLLOWING:

1. What I really care about is \_\_\_\_\_
2. I worry about \_\_\_\_\_
3. What I do best is \_\_\_\_\_
4. I have sometimes felt guilty about \_\_\_\_\_
5. What makes me angry is \_\_\_\_\_
6. My biggest mistakes were \_\_\_\_\_
7. My job is \_\_\_\_\_
8. My personality would be better if \_\_\_\_\_
9. I often felt that my mom/parent \_\_\_\_\_
10. My temper is \_\_\_\_\_
11. My childhood was \_\_\_\_\_
12. My biggest disappointment \_\_\_\_\_
13. To me, sex is \_\_\_\_\_
14. I would be better liked if \_\_\_\_\_
15. I often felt that my dad/parent \_\_\_\_\_
16. My (children/child) (siblings) \_\_\_\_\_
17. What I dream for is \_\_\_\_\_
18. What hurts me most is \_\_\_\_\_
19. My biggest problem in life is \_\_\_\_\_
20. My body is \_\_\_\_\_
21. What I really want is \_\_\_\_\_
22. Spirituality is \_\_\_\_\_