NEW CLIENT INFORMATION FORM

CLIENT NAME: ____ Date of Appt: ________ Date of Birth: __________ Age:________

Phone:_____________ Okay to leave a message? ___ y ___ n; Phone 2:____________ Okay to leave a message? ____ y ____ n

E-mail: ___________________________________ Address :______________________City: ___________State: ________Zip: ____________

EMERGENCY CONTACT NAME: ________________________ Phone:____________ Relationship:__________

Address :____City: _____________State: ________Zip: _______________

Psychiatrist: ____________________ Phone:____________; Physician: ________________ Phone: ____________

Reason for your visit: ____

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Previous Treatments: ____

____

What **medical conditions** do you (or the client) have or have you had in the past?_______________________________________

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Please list any **medications** you (or the client) are currently taking, along with the dosage, and the reason for taking them.

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Please identify any past **mental health diagnoses**: ____

Do you have any allergies? ____

Please select any of the following **symptoms** you (or the client) may have been experiencing:

☐ Depressed mood	☐ Thoughts of harming others	☐ Risk-taking Behavior	☐ Hyperactivity
☐ Loss of interest in things	☐ Muscle tension	☐ Irritability	☐ Increased Energy
☐ Anxiety/worry	☐ Pain	☐ Vomiting	☐ Defiance
☐ Hopelessness	☐ Restlessness	☐ Drug/alcohol abuse	☐ Panic Attacks
☐ Worthlessness/guilt	☐ Feeling physically slowed down	☐ Impulsive behavior	☐ Dieting
☐ Sleeping too much/ too little	☐ Feeling tired easily	☐ Nightmares	☐ Temper tantrums
☐ Weight gain/ weight loss	☐ Physical or Verbal Aggression	☐ Memory Loss	☐ Feeling like your eating is out of control
☐ Suicidal thoughts	☐ Self-injury	☐ Excessive Crying	☐ Grief over a loss
☐ Poor concentration	☐ Relationship Difficulties	☐ Feeling like your emotions are up and down	☐ _______________
☐ Indecisive	☐ Hearing or seeing unusual things	☐ Unusual thoughts	☐ _______________
☐ Social Problems	☐ Feeling compelled to engage in certain behaviors	☐ Excessive Fears	☐ _______________
☐ Avoiding activities/people/things	☐ Obsessive thoughts	☐ Trauma history	☐ _______________

Do you smoke cigarettes? Yes_____ No _____

Do you drink alcohol? Yes _____ No _____ If yes, How much? ____

Do you use any other non-prescribed mood altering substances? Yes____ No_____ If yes, which ones?____________________