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New Clients/Guardians: Please fill out this form and bring to your first appointment. Thank you! **DATE** _____

Client's Name: _____ ***Date of Birth:*** _____ ***Sex:*** ☐**M** ☐**F**

Address: _____

Contact Info: *Cell* _____ *Home*_____ *Email* _____

Person completing this form:_____ ***Relationship:***_____

- Please describe the problems for which are seeking help at this time:

_____

_____

_____

_____

_____

- When did the problem begin? _____

_____

_____

- Please share any known stress that caused or contributed to the problem:_____

_____

_____

Mental Health History

- If you have received outpatient mental health treatment in the past, please indicate below:

Clinician/M.D.	Dates of Treatment	Frequency of Visits

- If you have received inpatient mental health treatment in the past, please indicate below:

Hospital Name	Dates of Treatment	Reason for Hospitalization

- Please list any psychiatric medications you have taken in the past and/or are currently taking:

Rx Name	Reason Given	Dates Taken	Reason Stopped (if not current)

- If you have threatened or attempted suicide in the past or have current ideation (thoughts), please explain:

_____

_____

- If you have a family history of mental health conditions, please describe:_____

_____

_____

Substance Abuse History

- Do you have a substance abuse (including alcohol) problem or are you concerned about anyone else in your family having one? If so, please explain _____

_____

- Have you ever been treated on an outpatient or inpatient basis for substance abuse and if so, please indicate below:

Name of Facility	Dates	How Long	Outcome

- Did you grow up in a home where there was substance abuse? (including alcohol)_____

Medical History

- Who is your primary physician?_____ Phone #_____
- Please list all medications (other than psychiatric medications) you are currently taking:

Rx Name	Condition Treated	Prescribing MD

Social History

- Who do you currently live with? (please list ages of your children if you have any)_____

_____

- Is there a significant amount of tension in the home and if so, please explain:_____

_____

- Were you ever physically or sexually abused?_____
- What are your hobbies or interests?_____
- What is your highest degree of education?_____

(If client is a minor, are there any academic or behavioral concerns in school? Please explain: _____

_____

- Are you employed and if so, what type of work do you do?_____
- If you have a legal history, please indicate below:

Date Arrested	Charge(s)	City/County/State	Sentence	Describe what happened

Are you **currently** experiencing:

Rating Scale 1-10 (10 =worst)
Only rate the areas to which you say "yes"

- Depressed Mood or Sadness yes no _____
- Irritability/Anger yes no _____
- Mood Swings yes no _____
- Rapid Speech yes no _____
- Racing Thoughts yes no _____

- Anxiety yes no _____
- Constant Worry yes no _____
- Panic Attacks yes no _____
- Phobias yes no _____
- Sleep Disturbances yes no _____
- Hallucinations yes no _____
- Paranoia yes no _____
- Poor Concentration yes no _____
- Alcohol/Substance Abuse yes no _____
- Frequent Body Complaints (e.g., headaches) yes no _____
- Eating Disorder yes no _____
- Body Image Problems yes no _____
- Repetitive Thoughts (e.g., Obsessions) yes no _____
- Repetitive Behaviors (e.g., counting) yes no _____
- Poor Impulse Control (e.g., ↑ spending) yes no _____
- Self Mutilation yes no _____
- Sexual Abuse yes no _____
- Physical Abuse yes no _____
- Emotional Abuse yes no _____

Have you experienced in the **past**: Rating Scale 1-10 (10 =worst)
Only rate the areas to which you said "yes"

- Depressed Mood or Sadness yes no _____
- Irritability/Anger yes no _____
- Mood Swings yes no _____
- Rapid Speech yes no _____
- Racing Thoughts yes no _____
- Anxiety yes no _____
- Constant Worry yes no _____
- Panic Attacks yes no _____
- Phobias yes no _____
- Sleep Disturbances yes no _____
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- Repetitive Behaviors (e.g., counting) yes no _____
- Poor Impulse Control (e.g., ↑ spending) yes no _____
- Self Mutilation yes no _____
- Sexual Abuse yes no _____
- Physical Abuse yes no _____
- Emotional Abuse yes no _____

- If you have any spiritual/religious beliefs, what are they and how important is the practice of your faith?_____

_____

Thank You!