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NEW CLIENT HISTORY AND CONTACT INFORMATION

Date: _____

Name you go by (first, last):_____
Government Name (if different):_____

Date Of Birth: _____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____(H/W/C) _____(H/W/C)

Email address: _____

What is the best way to contact you? _____

Please list any safety concerns for telephone or email contact:
_____
_____
_____

Emergency Contact name :_____
Emergency Contact Phone number: _____

Relationship to you: _____

Client Name:
Date:

What word(s) would you use to describe your race and/or ethnicity?

_____

What Gender Pronoun(s) do you use:_____

- ☐ Prefer not to say

What words do you use to describe your gender identity:

_____

- ☐ Prefer not to say

Do you identify as transgender:

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

What words do you use to describe your sexual orientation?

_____

- ☐ Prefer not to say

Are you currently employed or in school (please include the name of employer/school if it applies)?

_____

_____

Do you have a protective order either against yourself or against a spouse/partner/other person?

Family members/Significant Relationships/Significant others in your life:

Do you have pets? Are they safe at home?

Client Name:
Date:

What is your experience with therapy? What worked well and what did you find less effective in sessions? Experiences with hospitalizations, groups, or other therapeutic environments?

Current supports such as a psychiatrist, physicians, counselors, therapists, and any others whom it may be beneficial for me to contact with your consent; please include contact information (A Release of Information will be necessary for any consultations or other communication):

Current medications, dosage, prescribing physician, duration, and reason for taking:

Past medications and reason for stopping them:

Please include any personal history with alcohol or drug use:

How did various family members handle stress? Are you aware of any family history related to alcohol or other substances? Please describe.

Are you aware of any family history of emotional health concerns or mental illness? Please describe.

Client Name:
Date:

Have you ever made a suicide attempt, wanted to do so, or made a plan to do so? Harmed yourself intentionally? If yes, please provide information so that we may discuss further.

Have you ever had a sense of hearing voices or sounds or seeing images that were not visible or heard by others? If so, please describe:

How is your sleep? About how many hours per day/night do you get? Do you feel rested?

Do you exercise or regularly move your body in a positive way – approximately how often? What form of exercise or body movement do you do?

How is your physical health? Please list any significant health issues, current or past:

Is there anything that you do, or have done, to release stress that works well?
Is there anything that you have tried that is not effective?

Do you have a spiritual practice or set of beliefs? Do you feel spiritually fulfilled? Please describe, in as much or as little detail as is comfortable.

Client Name:
Date:

Hobbie and interests (please also include whether you are actively involved in them currently):

Please describe the quality (supportive, non-supportive, satisfactory, good, excellent) of your peer relationships.

Are you currently physically safe?

Are you currently emotionally safe?

As far as you can remember, have you ever experienced (or witnessed) any form of physical/emotional/psychological abuse, sexual abuse/unwanted touching/invasion of body privacy, harassment, or stalking (including cyber stalking)? Controlling behaviors from another person? Are you afraid of any significant people in your life?
We will navigate this further, at your pace, in session(s). With that in mind, describe in whatever detail is comfortable for you, taking care not to activate emotional distress or re-traumatization.

As far as you can remember, have you encountered negative or impactful experiences related to race, ethnicity, nationality, culture, religion, sexual orientation, gender identity, gender expression, or other identities you hold?

Client Name:
Date:

How would you describe your reason(s) for beginning therapy? Was there a certain event or series of events? What do you want to get support with, guidance about, or see change?

What would you most like to experience as a result of working together?

Is there any other information about you that you think it would be helpful for me to know?

Do you have any questions for (or about) me? Do you have any concerns or fears about therapy?

_____

Client Signature

_____

Date

Thank you for taking the time to share this information!

Client Name:
Date: