HOPE & HEALING
Counseling

New Client Form (Adult) **Date** _____

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time.

General Client Information:

Name: (First, Middle, Last): _____ **DOB:** _____

Gender: _____ **Age:** _____ **Last 4 Soc #:** _____ **Ethnicity:** _____

Address: _____ **City:** _____

State: _____ **Zip code:** _____ **Home Phone:** _____ **Mobile Phone:** _____

Email address: _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Your Occupation: _____ **Employer:** _____

Referred by: _____ **May I thank your referral Source? ☐Yes ☐No**

Current Issues

In your own words, please describe what brings you to therapy at this time:

Has anything occurred that may have brought on or exacerbated your symptoms? ☐Yes ☐No
If yes, please describe the circumstances or events that you are referencing:

When (month and year) did you begin to experience these problems?

How often do you experience these issues?

- ☐ **Most of the day, every day**
- ☐ **Some part of the day, every day**
- ☐ **More than once a week**
- ☐ **More than once a month**

☐ **Other:**_____

When you experience these problems, how intense is the discomfort they bring?

☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **It varies (please explain):**

_____

What areas of your life are affected by these issues (please mark all that apply):

☐ **The way you live your life** ☐ **Activities** ☐ **Relationships** ☐ **Eating** ☐ **Sleeping** ☐ **Mood**

Current Symptoms

Instructions: Please check all that apply to you:

- ❑ Feeling depressed
- ❑ Low energy
- ❑ Low self-esteem
- ❑ Poor concentration
- ❑ Lack of interest/joy in life
- ❑ Feeling hopeless
- ❑ Feeling worthless
- ❑ Feeling guilty/shameful
- ❑ Sleep changes more/less
- ❑ Loneliness
- ❑ Bad dreams/Nightmares
- ❑ Feeling Ignored
- ❑ Feeling Abandoned
- ❑ Appetite change more/less
- ❑ Mood swings
- ❑ Isolating/Withdrawing
- ❑ Sadness/Loss
- ❑ Weight problems
- ❑ Stress/Worry/Anxiety
- ❑ Panic attacks
- ❑ Heart racing
- ❑ Chest pain or heaviness
- ❑ Chills/hot flashes
- ❑ Tingling/numbness in hands
- ❑ Pain
- ❑ Fear of dying
- ❑ Fear of going "crazy"
- ❑ Nausea
- ❑ Fears/Phobias
- ❑ Obsessions/Compulsions
- ❑ Thoughts racing
- ❑ Disorganized
- ❑ Procrastinates
- ❑ Can't hold onto an idea
- ❑ Anger/Frustration
- ❑ Suspicious/Mistrustful

Body image Problems

- ❑ Perfectionist behavior
- ❑ Lying
- ❑ Trouble with friendships
- ❑ Frequently Argues
- ❑ Destroys property
- ❑ Impulsive
- ❑ Excessive behaviors
- ❑ Unusual beliefs
- ❑ Hallucinations
- ❑ Sexual problems
- ❑ Self injurious behaviors
- ❑ Eating problems
- ❑ Shopping Compulsion
- ❑ Shy
- ❑ Lack of social support
- ❑ Steals
- ❑ Unusual behavior
- ❑ Feels confused
- ❑ Feels "not real"
- ❑ Feels detached
- ❑ Feels "hyper"
- ❑ Financial problems
- ❑ Grieving/bereaved
- ❑ Health problems
- ❑ Loses track of time
- ❑ Problems with memory
- ❑ Unpleasant thoughts
- ❑ Recurring bad thoughts
- ❑ Work/School Problems
- ❑ Career indecision
- ❑ Experienced Trauma
- ❑ Self-critical
- ❑ Family problems
- ❑ Relationship problems
- ❑ Parent/child problems
- ❑ Uses alcohol/drugs
- ❑ Gambling Compulsion
- ❑ Sexual Compulsion
- ❑ Blackouts
- ❑ Abuse **(Past)**
  - ❑ Emotional
  - ❑ Physical
  - ❑ Sexual
  - ❑ Domestic Violence
  - ❑ Spiritual
  - ❑ Other:_____
- ❑ Abuse **(Current)**
  - ❑ Emotional
  - ❑ Physical
  - ❑ Sexual
  - ❑ Domestic Violence
  - ❑ Spiritual
  - ❑ Other:_____
- ❑ Witnessed Trauma
- ❑ Death of Someone Close
- ❑ Other(s):

History

If you have received outpatient-counseling services in the past, please fill in the blanks below:

Beginning Month/Year	Therapist's Name	Purpose	Length of Therapy	Reason(s) for Ending Treatment

If you have received inpatient psychiatric services in the past, please fill in the blanks below: _____N/A

Date (Month/Year)	Facility/Hospital	Reason

Have you been contemplation suicide? ☐ **Yes** ☐ **No**

Have you ever attempted suicide? ☐ **Yes** ☐ **No**

Have you been contemplation harming or killing someone else? ☐ **Yes** ☐ **No**

Have you ever harmed or killed someone else? ☐ **Yes** ☐ **No**

If you answered yes to any of the above questions, please comment below:

Please describe any allergies or drug sensitivities you may have:

Current Medications:

First Rx Mo/Yr	Name of Medication	Dosage	Taken How Often?	Prescribed by:

☐ Additional info on the back of this page

Past Psychiatric Medications:

Length of time Taken	Name of Medication	Discontinued because:	Prescribed by:

Current Primary Care or Psychiatric Medical Provider(s):

Name	City/State	Phone

Please describe any significant medical history (surgeries, serious illnesses/injuries, etc.)

Current Life Circumstances

My sources of satisfaction: _____

My sources of stress: _____

My leisure activities: _____

My current life goals: _____

What I hope to gain from counseling/therapy:

Please choose the options that describe your current living arrangements:

I live in a/an: Apartment ❑ House ❑ Condo/Townhouse ❑ Mobile Home ❑ Rooming House ❑ Other: _____

❑ I Own ❑ I Rent ❑ I live alone ❑ I live with family ❑ I live with friends ❑ I live with roommate(s) ❑ Other: _____

I have a pet: ❑ Yes ❑ No What kind of pet(s) do you own? _____

What are your pet's Name(s): _____

How important are your pets to your well-being? ❑ Not very ❑ Somewhat ❑ Very

The significant people in my life who live with me are:

Name	Age	Relationship to me	Problems?

The significant people in my life who live apart from me are:

Name	Age	Relationship to me	Problems?

Please note any current or previous use of street drugs, tobacco products, or alcohol: ❑ **N/A**

Dates:	Type Used:

Problems/Changes in my personal or work relationships that affect my well-being include:

Name	Relationship to me	Issue	Start date

Problems/changes in my occupational, educational, social, or recreational functioning that affect my well-being include:

Setting	Issue	Start Date

My typical day is as follows (attach extra sheets, if necessary):

Family of Origin/Developmental History

Please list the members of your family of origin in the order that they were born. Include current ages.
(*Example: Maternal grandmother (deceased), Mother (age 50), father (age 49), sister Anne (age 29), brother Larry (age 27), me (age 24) lived in the childhood home).*

Please describe the background or status of your family of origin in these areas:

Financial Status/Income Level: _____

Social Status in the Community: _____

Religion/Religious Practices: _____

Cultural/Ethnic Background: _____

Briefly describe any of the following that apply to your family of origin:

Crisis or other significant events:

Emotional, psychological, or physical illness:

Parenting styles: **(who did what and how?)**

Communication styles: **(who talked, who didn't, how?)**

Using 3 words or less, describe your childhood/adolescent relationships and current relationships with each of the following people **(e.g. close, conflicted, jealous, angry, abusive, loving, intrusive). Please place an X in any spaces that do not apply.**

Person	Relationship Then	Relationship Now
Mother		
Father		
Stepparent		
Siblings		
Mentors		
Spouse or significant other		
In-laws		
Children		

Stepchildren _____

Grandchildren _____

Employer _____

Coworkers _____

Employees _____

Other _____

Comments: _____

_____

Please describe any factor that had significant impact on your development (from Birth to Adulthood) during your childhood and adolescence (e.g. illnesses, death of a parent, sexual abuse, separation from primary caregivers). Please include how these impacts affected you.

_____

_____

_____

_____

Thank you for taking the time to complete this form. Please sign below to indicate that the information included herein is an accurate portrayal of your life and experiences and is based upon your personal input:

_____

Signature **Date**