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NEW CLIENT REGISTRATION AND INFORMATION (CONFIDENTIAL)

Date: _____

Part I. Personal Information

Last Name: _____ First Name: _____

Home Address: _____

_____

_____

E-Mail Address: _____

Phone Numbers: Home _____ O.K to call: □ yes □ no

Cell _____ O.K to call: □ yes □ no

Work _____ O.K to call: □ yes □ no

Date of Birth: _____ Age:_____

Marital Status:

□ Married/Living in a Committed Relationship

Name of Spouse/Partner _____

□ Single

□ Divorced

□ Widowed

Do you have children? If yes, how many and their ages:

_____ _____

Number of Children Names and Ages

Schools children attend: _____

Referred by (if any): _____

Emerg. contact: _____ Relationship: _____Phone:_____

Medical Insurance _____ID#_____

Insured's Name (if different) _____

Insured's DOB: _____Patient's Social Security #:_____

Part II.Employment Information

Are you currently employed? □ Yes □ No

Company Name: _____

Occupation: _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

If you are a student, please indicate your school and year _____

Part III. Medical/Mental Health Information

Current Medications Dose and frequency Began (Month and Year)

_____

_____

_____

List your primary care physician, psychiatrist, or any other clinicians involved in your care:

Name Address Phone

_____

_____

_____

Have you ever been in psychotherapy before? □ Yes □ No

If yes, when?

_____

May I contact your previous therapist (s)? □ Yes □ No

Therapist:

_____

Address:

_____

Phone:

_____

How would you rate yourcurrent physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

Are you currently experiencing any chronic pain? □ Yes □ No
If yes, please describe.

_____

_____

_____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

_____

Are you currently experiencing sadness, grief or depression? □ Yes □ No
If yes, when did you begin experiencing this? Please describe your symptoms:

_____

_____

_____

Have you ever made a suicide attempt? If yes, describe it, when, and the circumstances leading up to it.

_____

_____

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If yes, when was the last date of hospitalization and reason for hospitalization?

_____

_____

Are you currently experiencing anxiety, panic attacks or have any phobias? □ Yes □ No

If yes, when did you begin experiencing this? Please describe your symptoms:

_____

_____

_____

Have you ever experienced hearing voices that appear to be "in your head"? □ Yes □ No

If yes, please describe? _____

Do you drink alcohol more than once a week? □ Yes □ No

Do you use drugs? □ Yes □ No

Part IV: Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Please Circle		List Family Member
Alcohol/Substance Abuse	□ Yes □ No	
Anxiety	□ Yes □ No	
Depression	□ Yes □ No	
Domestic Violence	□ Yes □ No	
Eating Disorders	□ Yes □ No	
Obesity	□ Yes □ No	
Obsessive Compulsive Behavior	□ Yes □ No	
Schizophrenia	□ Yes □ No	
Suicide Attempts	□ Yes □ No	

Part V: Additional Information

1) Do you consider yourself to be spiritual or religious? □ Yes □ No
If yes, describe your faith or belief:

_____

2) What do you consider to be some of your strengths?

_____

_____

3) What do you consider to be some of your weakness?

_____

_____

4) Do you have supportive people in your life at this time with whom you can confide your problems?

_____

_____

5) When you are faced with difficulties, what is your usual manner of coping?

_____

_____

6) Please describe your primary reason for seeking treatment at this time. How long has this problem existed?

_____

_____

_____

7) What are your goals for your therapeutic process?

_____

_____

_____

_____

_____