

New Client Information Form

Today's Date: _____

Client Name: _____
(To be completed by Parent/Guardian if client is younger than 18 years)

Date of Birth: _____ **Age:** _____ **SS#:** _____

Address: _____

Phone Number(s): Home _____ **Work:** _____
May I call you ...at home? ___yes ___no ...at work? ___yes ___no
Cell Phone _____ Email _____

Marital Status: () Single () Divorced – Date _____
() Married – Date _____ () Living Together – Date _____
() Separated - Date _____ () Widowed

Employer/School: _____ **Occupation:** _____

Names of people living in home _____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Names of children not in home _____ Age _____
_____ Age _____
_____ Age _____
_____ Age _____

Person to be contacted in case of emergency:

Name: _____ **Relationship:** _____

Home Phone #: _____ **Work Phone #:** _____

Referred by: _____

Therapy History:

Have you ever received **psychological** or **psychiatric** treatment of any kind before? Yes No

If you checked **Yes** to the above question, please answer the following:

What type of care did you receive? Inpatient Outpatient Both

Where were you in treatment? _____

How long were you in treatment? _____

Who was your therapist/doctor? _____

Did your doctor prescribe medicine at that time? Yes No N/A

If Yes, what was prescribed? (Include dosages if known) _____

Family History:

Describe any significant emotional, medical, or chemical dependency conditions of your parents and/or family members:

Substance Use History:

Have you ever abused drugs or alcohol? Yes No **If Yes, please describe:**

Substances	Amount	Frequency	When? (1 st Use, Last Use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If Yes, have you ever received substance abuse treatment of any kind before? Yes No

Do you have a history of blackouts, seizures or withdrawal symptoms? Yes No

Please describe anything else you would like your clinician to know:
