NEW CLIENT BACKGROUND

To allow us to best serve you, please complete this form with as much accuracy and honesty as possible.

Last Name: ______________________________________ First: _______________________________

Date of Birth: ______________________________ Age: _____________ Gender: ________________

YOUR PERSONAL HISTORY

Place of birth: ____

Please list previous places you have lived: ____

____

Height: _________Weight: ___________ Last Physical Exam: _________________________________

Primary Care Physician: _______________________________ Phone _________________________

Psychiatrist: ____ Phone _________________________

Marital Status: Married / Divorced / Widowed / Separated / Single / Living with Partner

Number of times married: _________________ Number of children: ____________________________

Names and ages of children____

Where are children living now? ____

____

Please describe **your** feelings regarding your current situation: _________________________________

____

____

YOUR FAMILY HISTORY

Please list significant family members (parents, siblings and others), living and deceased, their relationship to you and their approximate ages.

Note if applicable: SA= substance abuse, MI = mental illness, VS = violence to self, VO = violence to others

Name	Relationship	Age

With whom do you currently reside? ____

Please give the names of family members, **including you,** who are presently, or in the past have been, under the care of a mental health professional and/or in a substance abuse program:

Name	**Issue**	**Seen when and where**

Have you ever deliberately hurt yourself? Yes / No

Have you ever attempted suicide? Yes / No

Have you ever assaulted another person? Yes / No

Do you have a history of fire setting? Yes / No

Do you have a history of animal cruelty? Yes / No

CURRENT PHYSICAL HEALTH

Current Health Issues	**By whom are you being treated?**

Any known allergies: ____________________

Current medications: ____________________

Are you compliant with your prescribed medications? Yes / No Not Applicable

Previous significant health problems (illnesses and surgeries):____________________

____

____

Previous hospitalizations (medical and psychiatric):____________________

____

SUBSTANCE USE INFORMATION

Do you drink regular coffee? No / Yes.......... ………How many cups per day? ____________________

Do you smoke cigarettes? No / Yes………………How many per day? ____________________

Do you drink alcohol? No / Yes…………….. How much per week? ____________________

Do you use other drugs? No / Yes………………Name(s) ____________________

Date of last use (drugs or alcohol) ____________________

SCHOOL / EDUCATION / RELIGIOUS HISTORY

Please describe your educational history: Highest grade completed, certificates, training:

____

____

____

Military Service: Yes / No Branch: ____________________

Discharge Type: Honorable / Dishonorable / Medical

Current Occupation: ____________________

Current Employer: ____________________

Please list the types of jobs you have held in the past: ____________________

____

Please list past/present religious affiliations and/or name(s) of place(s) of worship:

____

____

List any cultural beliefs that may interfere with your treatment: ____________________

____

PEER INTERACTION AND SELF PERCEPTION

In the past few years have you had difficulty getting along with others? ____________________

What feedback do you get about yourself from others? ____________________

How do you generally handle your anger? ____________________

Has your anger even gotten you into trouble, if so how? ____________________

____

What do you consider your character strengths?

____

What do you consider your character weaknesses?

____

Do you have a best friend? ____________________

How do you unwind / relax? ____________________

Do you have a hobby? ____________________

What do you do for fun? ____________________

PROBLEM AREAS

Circle the areas in which you are experiencing difficulties at this time:

Acute Pain	Elevated mood	Marital issues	Seeing things
Alcohol Use	Energy level	Memory	Self control
Ambition	Family	Mood swings	Self mutilation
Anger	Fears	Motivation	Separation
Anxiety	Finances	Nervousness	Sexual issues
Appearance	Friends	Nightmares	Shyness
Appetite	Gambling	Occupational issues	Sleep
Bowel troubles	Habits	Panic	Stomach trouble
Career choice	Health	Paranoia	Stress
Chronic pain	Hearing voices	Parenting	Study habits
Concentration	History of abuse	Racing thoughts	Suicidal thoughts
Decision making	Impulsive behavior	Relationships	Tiredness
Depression	Inferiority	Relaxation	Unhappiness
Distressing thoughts	Legal issues	Repeating thoughts	Weight
Drug use	Loneliness	Resentment	Other:_____________
Eating habits	Love / Affection	Revengeful thoughts	___________________

PRESENTING PROBLEM:

If there is one, please describe the **specific** issue that has brought you to our office:

____

____

____

Describe your current feelings about the issue: ____

____

____

What steps have you already taken to correct the issue? ____

____

____

Please give any other information that you feel is relevant: ______________________________________

____

____

How do you want us to help you? ____

____

____

If your family is aware, what is their attitude toward your issue?

____

____

If applicable, describe benefits obtained through previous treatment:

____

____

LEVELS OF COPING SKILLS

On a Scale of 1 – 10, With 10 Being the Best,

What Is Your Current Level Of Coping? ________________________________

What Is Your Highest Level Of Coping In The Past Year? ____________________

Signature ____________________________________ Date ______________________