New Client Information

Mental Health Services

Date: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ ZIP: _____

Date of Birth: _____ Age:____ Sex: M ___ F ___ SSN: _____

Phone: _____ Email: _____

Preferred way to be contacted: _____

If client is under 18, please provide the following information for a parent or guardian:

Last Name: _____ First Name: _____

Relationship to client: _____ Phone: _____

Emergency contact:

Last Name: _____ First Name: _____

Relationship to client: _____ Phone: _____

Do you take any prescription medication?

Medication: _____ For: _____Since: _____

Medication: _____ For: _____Since:_____

Medication: _____ For: _____Since: _____

Medication: _____ For: _____Since: _____

Have you ever been diagnosed with a mental health disorder (e.g. depression, anxiety, ADHD)?

_____

Information about your concern or problem

Please describe briefly the concern that brings you here today:

_____
_____
_____
_____

How long have you been experiencing this concern?

_____

Have you had this or similar concerns in the past? If yes, please describe.

_____
_____
_____
_____

What have you tried so far that has helped and that has not helped?

Helped:

_____
_____

Didn‘t help:

_____
_____

How did you hear about our services?

_____

What is your goal for counseling?

_____
_____
_____
_____