# NEW CLIENT INFORMATION FORM

Your responses will help me better understand your experiences and develop the most effective treatment plan for your needs. Please answer each question as honestly and thoroughly as you can.

## 1. Demographic Information

Full Name _____Date of Birth:_____

Place of Birth:_____Marital Status: _____

Address:_____

_____

Phone (Cell):_____Email Address: _____

Emergency Contact Name:_____Relationship:_____

Emergency Contact Phone:_____Email:_____

Emergency Contact Address: _____

Insurance Company:_____Member ID:_____

Subscriber Name:_____Relationship to Subscriber:_____

Household Information (Include relationship and ages):_____

_____

_____

_____

## 2. Presenting Problem & Treatment Goals

**What concerns led you to seek therapy at this time?**

_____

_____

_____

_____

**How long has this been a problem?**

_____

**What have you already tried to help with this problem?**

_____

_____

_____

**What are you hoping will be different as a result of therapy?**

_____

_____

_____

**What are your top three goals for therapy?**

1._____

2._____

3._____

## 3. Past Psychiatric History

Check all that apply:

☐ Previous psychotherapy/counseling ☐ IOP/PHP ☐ Psychiatric hospitalization

☐ Self-harm/non-suicidal self-injury ☐ Suicide attempt ☐ None of the above

**Describe any previous psychotherapy, psychiatric treatment, or hospitalization.**

_____

_____

_____

**Have you ever been diagnosed with a mental health condition?** ☐ Yes ☐ No ☐ Not sure

If yes, list diagnoses and approximate dates: _____

_____

_____

**Please list any current or previous psychiatric medications and indicate whether they were helpful.**

_____

_____

_____

## 4. Safety Assessment

Have you ever:

Had thoughts of ending your life? ☐ Yes ☐ No

Attempted suicide? ☐ Yes ☐ No

Engaged in self-harm? ☐ Yes ☐ No

Had a plan or intent to harm yourself or others? ☐ Yes ☐ No

Had thoughts of harming others? ☐ Yes ☐ No

If you answered "Yes" to any of the above, please describe (including when).

_____

_____

_____

## 5. Medical History

**Current medical conditions:**

_____

_____

**Past significant medical problems, surgeries, or hospitalizations:**

_____

_____

**Current medications:**

_____

_____

**Allergies (medications, environment, food, etc.):**

_____

## 6. Substance Use (type, amount, frequency):

Alcohol:_____

Marijuana:_____

Nicotine / Tobacco:_____

_____

Other Drugs / Substances:_____

_____

History of substance treatment? ☐ Yes ☐ No

If yes, please describe: _____

_____

## 7. Social History

Relationship status:_____Spouse/Partner Name:_____

If married or in a relationship, how many years?_____

Children (names & ages), if applicable:_____

_____

Highest level of education completed:_____Major/area of study: _____

Employment/Occupation:_____

If employed, how many years at current job: _____

If unemployed, reason, and how long: _____

**Previous significant relationships:**_____

_____

## 8. Developmental History

**Who primarily raised you during childhood?**

_____

**If you were raised by someone other than your parents, please explain.**

_____

_____

**Describe your parents' relationship with each other during your childhood.**

_____

_____

_____

**Describe your relationship with your mother during childhood and currently.**

_____

_____

_____

**Describe your relationship with your father during childhood and currently.**

_____

_____

_____

**Describe your relationship with your siblings during childhood and currently.**

_____

_____

_____

**Other important childhood or developmental information.**

_____

_____

_____

## 9. Trauma History (You only need to include information you feel comfortable sharing today.)

Describe any abuse, neglect, bullying, losses, traumatic experiences, or other significant childhood or life events.

_____

_____

_____

_____

_____

_____

## 10. Family Psychiatric History

Describe any family history of mental health disorders, substance use disorders, or suicide (include relationship to you).

## 11. Treatment Goals

Is there anything else you hope therapy will help you achieve?

## 12. Additional Information & Signature

Is there anything else you would like me to know about you or your history?

Client Signature: _____

Date Completed: _____