

S T I L L W A T E R S  
Counseling and Psychotherapy

New Client Form

Date \_\_\_\_\_

**Instructions:** Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

**General Client Information**

Name: (First, Middle, Last) \_\_\_\_\_ Gender: \_\_\_ Age: \_\_\_ DOB: \_\_\_\_\_ Soc #: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Where may we leave a Voice Message?  Home Phone  Cell Phone

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Ethnic/Cultural Background: \_\_\_\_\_ Religion: \_\_\_\_\_

Native Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Education (highest degree/grade/level): \_\_\_\_\_

Occupation: \_\_\_\_\_ Annual Income: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ **May I thank your referral source?**  Yes  No

**Health Insurance Information**

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth of Subscriber: \_\_\_\_\_ Co-Pay: \_\_\_\_\_

Relation to Client: \_\_\_\_\_ Place of Employment of Subscriber: \_\_\_\_\_

**Current Issues**

**Please provide a brief description of why you are seeking counseling/therapy services at this time:**

Has anything happened that may have brought on/intensified the problems you are experiencing?  Yes  No

If yes, please explain: \_\_\_\_\_

When (month/year) did you first begin to experience these problems? \_\_\_\_\_

How many days, weeks, months, or years have you been experiencing these problems? \_\_\_\_\_

How often do you experience these problems? (Check the one that best describes your current experience).

- Most of the day, every day
- Some part of the day, every day
- Most of the day on most days
- Some part of the day on most Days
- More than once a week
- More than once a month
- Other \_\_\_\_\_

S T I L L W A T E R S  
Counseling and Psychotherapy

How much is/are the problems affecting you?     Mildly     Moderately     Severely

In what areas do your problems impact your life? (Check all that apply)

- Lifestyle (the way you live your life)
- Activities (things you normally do or would like to do)
- Relationships (your ability to form or maintain relationships with others)
- Eating
- Sleeping
- Mood

Have you ever attempted suicide?     Yes     No    If yes, when? \_\_\_\_\_

Have you been thinking about suicide?     Yes     No

Have you ever thought about harming or killing someone else?     Yes     No    If yes, when? \_\_\_\_\_

Have you been thinking about harming or killing someone else?     Yes     No

**Adult Problems Checklist**

**Instructions: Please check all that apply to you**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Feeling depressed       | <input type="checkbox"/> Pain                      | <input type="checkbox"/> Eating problems         | <input type="checkbox"/> Sexual Compulsion        |
| <input type="checkbox"/> Low energy              | <input type="checkbox"/> Fear of dying             | <input type="checkbox"/> Body image Problems     | <input type="checkbox"/> Gambling Compulsion      |
| <input type="checkbox"/> Low self-esteem         | <input type="checkbox"/> Fear of going "crazy"     | <input type="checkbox"/> Shyness                 | <input type="checkbox"/> Shopping Compulsion      |
| <input type="checkbox"/> Poor concentration      | <input type="checkbox"/> Nausea                    | <input type="checkbox"/> Lack of social support  | <input type="checkbox"/> Blackouts                |
| <input type="checkbox"/> Lack of interest/joy    | <input type="checkbox"/> Fears/Phobias             | <input type="checkbox"/> Stealing                | <input type="checkbox"/> Abuse ( <b>Past</b> )    |
| <input type="checkbox"/> Feeling hopeless        | <input type="checkbox"/> Obsessions                | <input type="checkbox"/> Unusual behaviors       | <input type="checkbox"/> Physical                 |
| <input type="checkbox"/> Feeling worthless       | <input type="checkbox"/> Compulsions               | <input type="checkbox"/> Feeling confused        | <input type="checkbox"/> Sexual                   |
| <input type="checkbox"/> Feeling guilty/shameful | <input type="checkbox"/> Thoughts racing           | <input type="checkbox"/> Feeling "not real"      | <input type="checkbox"/> Domestic Violence        |
| <input type="checkbox"/> Sleep changes ↑ or ↓    | <input type="checkbox"/> Disorganization           | <input type="checkbox"/> Feeling detached        | <input type="checkbox"/> Emotional                |
| <input type="checkbox"/> Loneliness              | <input type="checkbox"/> Procrastination           | <input type="checkbox"/> Feeling "hyper"         | <input type="checkbox"/> Spiritual                |
| <input type="checkbox"/> Bad dreams/Nightmares   | <input type="checkbox"/> Can't hold onto an idea   | <input type="checkbox"/> Financial problems      | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Feeling Ignored         | <input type="checkbox"/> Anger/Frustration         | <input type="checkbox"/> Grief/bereavement       | <input type="checkbox"/> Abuse ( <b>Current</b> ) |
| <input type="checkbox"/> Feeling Abandoned       | <input type="checkbox"/> Suspiciousness            | <input type="checkbox"/> Health problems         | <input type="checkbox"/> Physical                 |
| <input type="checkbox"/> Appetite change ↑ or ↓  | <input type="checkbox"/> Mistrustfulness           | <input type="checkbox"/> Losing track of time    | <input type="checkbox"/> Sexual                   |
| <input type="checkbox"/> Mood swings             | <input type="checkbox"/> Perfectionist behavior    | <input type="checkbox"/> Problems with memory    | <input type="checkbox"/> Domestic Violence        |
| <input type="checkbox"/> Isolating               | <input type="checkbox"/> Lying                     | <input type="checkbox"/> Unpleasant thoughts     | <input type="checkbox"/> Emotional                |
| <input type="checkbox"/> Social withdrawal       | <input type="checkbox"/> Trouble making friends    | <input type="checkbox"/> Recurring bad thoughts  | <input type="checkbox"/> Spiritual                |
| <input type="checkbox"/> Sadness/Loss            | <input type="checkbox"/> Trouble keeping friends   | <input type="checkbox"/> Work/School Problems    | <input type="checkbox"/> Other: _____             |
| <input type="checkbox"/> Weight problems         | <input type="checkbox"/> Arguing                   | <input type="checkbox"/> Career indecision       | <input type="checkbox"/> Legal Problems           |
| <input type="checkbox"/> Stress/Worry            | <input type="checkbox"/> Unusual rituals or habits | <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Experienced Trauma       |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Impulsiveness             | <input type="checkbox"/> Self-criticism          | <input type="checkbox"/> Witnessed Trauma         |
| <input type="checkbox"/> Panic attacks           | <input type="checkbox"/> Excessive behaviors       | <input type="checkbox"/> Family problems         | <input type="checkbox"/> Loss of a relationship   |
| <input type="checkbox"/> Heart racing            | <input type="checkbox"/> Unusual beliefs           | <input type="checkbox"/> Relationship problems   | <input type="checkbox"/> Death of someone close   |
| <input type="checkbox"/> Chest pain or heaviness | <input type="checkbox"/> Hallucinations            | <input type="checkbox"/> Parent/child problems   | <input type="checkbox"/> Other (please describe): |
| <input type="checkbox"/> Chills/hot flashes      | <input type="checkbox"/> Sexual problems           | <input type="checkbox"/> Use of alcohol          |   |
| <input type="checkbox"/> Tingling/numbness       | <input type="checkbox"/> Self injurious behaviors  | <input type="checkbox"/> Use of drugs            |   |

S T I L L W A T E R S  
Counseling and Psychotherapy

Current Life Experiences

I live in a/an:  Apartment  House  Condo/Townhouse  Mobile Home  Rooming House  Other

I live with:

<u>Name</u>	<u>Age</u>	<u>Relationship to me</u>	<u>Problems?</u>
-------------	------------	---------------------------	------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other significant persons in my life who do not live with me include:

<u>Name</u>	<u>Age</u>	<u>Relationship to me</u>	<u>Problems</u>	Lives where?
-------------	------------	---------------------------	-----------------	--------------

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Problems or changes in my family or other important interpersonal relationships:

<u>Date(s)</u>	<u>Persons Involved</u>	<u>Relationship to me</u>	<u>Problems or Changes</u>
----------------	-------------------------	---------------------------	----------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Problems or changes in occupational, educational, social, or recreational functioning:

<u>Date(s)</u>	<u>Problems or Changes</u>
----------------	----------------------------

_____	_____
_____	_____
_____	_____

My sources of satisfaction: \_\_\_\_\_

My sources of stress: \_\_\_\_\_

My leisure activities: \_\_\_\_\_

My current life goals: \_\_\_\_\_

What I hope to gain from counseling/therapy: \_\_\_\_\_

My typical day is as follows (attach extra sheets, if necessary):

S T I L L W A T E R S  
Counseling and Psychotherapy

**History of Counseling or /Therapy**

Are you currently being treated by a counselor, psychologist, psychiatrist, and/or physician for the problems noted above?  
 Yes  No If yes, please provide the following information:

Date(s)	Name of Professional	Address	Treatment Type (counseling, therapy, medication, etc.)

Please provide information regarding previous treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional	Address	Treatment Type	Why treatment ended

Have you ever been hospitalized for treatment of an emotional or mental disorder?  Yes  No  
If yes, please provide the following information:

Date(s)	Name of Hospital or Facility	Address	Reason for Hospitalization

**Medical History**

Please complete the information below regarding past and current medical conditions and treatment:

Date(s)	Physician Name / Address	Condition	Treatment	Results

Please list any allergies/sensitivities/drug reactions:  
\_\_\_\_\_  
\_\_\_\_\_

Please list all current prescription and over the counter medication use:

Beginning (date)	Medication	Dose	Frequency of use	Condition Treated

Client: \_\_\_\_\_  
File # \_\_\_\_\_

S T I L L W A T E R S  
Counseling and Psychotherapy

Please list any previous prescription and over the counter medication use significant to your counseling/therapy:

Date(s)	Medication	Dose	Frequency of use	Condition Treated

Please note any current or previous use of street drugs, tobacco products, or alcohol:

Date(s)	Type Used	Frequency of Use	Amount Typically Used	When ended (if applicable)

Please list any hospitalizations or surgeries:

Date(s)	Hospital/Facility	Physician	Condition	Type Treatment/Surgery

**Family of Origin**

Please list the members of your family of origin in the order that they were born. Include current ages. Example: Maternal grandmother (deceased), Mother (age 50), father(age 49), sister Anne (age 29), brother Larry (age 27), me (age 24) lived in the childhood home.

Please describe the background or status of your family of origin for the following categories:

Ethnic: \_\_\_\_\_ Religious: \_\_\_\_\_  
Social: \_\_\_\_\_ Financial: \_\_\_\_\_

Briefly describe any of the following that apply to your family of origin:

- Crisis or other significant events:
- Any emotional, psychological, or physical illness: (Examples: cancer, diabetes, heart disease, depression, alcoholism, drug abuse or addiction, family violence, depression, suicide)
- Parenting styles of your mother, father, and other caretakers? Who did what and how?
- Communication styles in your family of origin? Who did most of the talking, teaching, and connecting?

S T I L L W A T E R S  
Counseling and Psychotherapy

- Please use 3-5 words to describe your childhood/adolescent relationship with the following family members (e.g. close, conflicted, jealous, angry, abusive, loving, intrusive)

Mother:

Father:

Stepparent:

Siblings:

Other significant family members/Friends/Mentors:

- Please describe your current relationship with the following family members

Mother:

Father:

Stepparent:

Siblings:

Other significant family members/Friends/Mentors:

Spouse, or significant other:

In-laws:

Your Children/Stepchildren/Grandchildren:

Your employer/coworkers:

Client: \_\_\_\_\_  
File # \_\_\_\_\_

S T I L L W A T E R S  
Counseling and Psychotherapy

**Developmental History**

Briefly describe your (1) physical, (2) psychological, (3) emotional, (4) intellectual, (5) social, (6) spiritual, and (6) academic development, and (7) any significant experiences affecting you during the following stages of your life (attach extra sheets, if needed):

Prenatal development and infancy (conception up to age 2):

Early Childhood (age 2 through age 5):

Middle and Late childhood (age 6 through age 11):

Adolescence (age 12 through age 17):

Adulthood (age 18 and up):

Client/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_