Caring Journey Counseling

NEW CLIENT FORM

Please fill out this form and bring it to your first session, where we will explore the problems you have indicated in more depth. Please note: information you provide here is protected as confidential information.

Name: _____ Date of birth: ____ /____ /____ Age: ____ Gender: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: ( ) _____ Is it okay to leave a message with someone in your household? □ Yes □ No
Is it okay to leave a voicemail? □ Yes □ No

Cell Phone: ( ) _____ Is it okay to leave a voicemail? □ Yes □ No
Is it okay to text you? □ Yes □ No

Work/ Other Phone: ( ) _____ Is it okay to contact you at this number? □ Yes □ No

E-mail: _____ *Please note: Email correspondence is not considered to be a confidential medium of communication.

Name of parent(s)/guardian(s) (if under 18 years):

_____
(Primary Parent/Guardian) (Address) (Phone)

_____
(Primary Parent/Guardian) (Address) (Phone)

Emergency contact: _____
(Name) (Relationship) (Phone)

Marital Status:
□ Single/ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list all others living in the home and their ages: _____

_____

Current Employer: _____ Attending School at: _____

Insurance Company: _____ ID #: _____

How did you find out about Caring Journey Counseling?_____

By signing below, **I *agree* and *consent to mental health treatment* at Caring Journey Counseling.**

_____ _____
(Client signature) (Date) (Parent/Guardian signature) (Date)

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, treatment program, group, etc.)?
□ No □ Yes, Please list previous therapist(s)/ mental health services(s): _____
_____

2. Have you ever been prescribed psychiatric medication in the past?
□ No □ Yes; Please list: _____
_____

3. Are you currently taking any prescription medication?
□ No □ Yes; Please list: _____
_____

4. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:
_____

5. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____

6. How many times per week do you generally exercise? _____ What types of exercise/ physical activity do you participate in? _____

7. Please list any difficulties you experience with your appetite or eating patterns:
_____

8. Are you currently experiencing any chronic pain?
□ No □ Yes If yes, please describe: _____

9. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

On a scale from 1-10, how severe is your anxiety when it is at its worst? _____

10. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

Have you **ever** experienced any suicidal thoughts? □ No □ Yes

Have you experienced any suicidal thoughts **in the past three months**? □ No □ Yes

Have you **ever** engaged in self-harm behavior? □ No □ Yes

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Have you engaged in self-harm behavior **in the past three months**? □ No □ Yes

Have you **ever** been hospitalized for suicidal thoughts or attempts, or self-harm behavior? □ No □ Yes

If yes, when, and how long was your hospital stay(s)? _____
_____

11. Do you **currently** drink alcohol? □ No □ Yes

If yes, how frequently do you drink, on average, and how much alcohol do you drink in one sitting, on average?
_____

Do you **currently** use any drugs for recreational purposes (prescribed or street): □ No □ Yes

Have you used alcohol or drugs **in the past** (including experimental use)? □ Never □ Yes

12. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

On a scale of 1-10, how would you rate your satisfaction with your relationship? _____ Please list any problems you are experiencing in your relationship: _____
_____

13. Have you ever experienced any form of abuse or neglect? This can include physical abuse, any type of unwanted sexual contact, or domestic violence. □ No □ Yes

14. What significant life changes or stressful events have you experienced recently? _____
_____
_____

15. Are you currently employed? □ No □ Yes If yes, do you enjoy your work? _____ Is there anything stressful about your current work? _____
_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member(s), if applicable
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
ADHD/ ADD	yes/no	_____
Eating Disorders	yes/no	_____
Bipolar Disorder	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Delusions/ Hallucinations	yes/no	_____
Suicide Attempts	yes/no	_____
Personality Disorders	yes/no	_____

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ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:
_____

2. What do you consider to be some of your strengths? _____
_____
_____

3. What do you consider to be some of your weakness? _____
_____
_____

4. What would you like to accomplish out of your time in therapy? _____
_____
_____
_____
_____

5. Is there any other information you would like to share that is relevant to you as a person, the problems you are experiencing, or to past history? _____
_____
_____
_____
_____
_____