



**NEW CLIENT INFORMATION**

Referred By: \_\_\_\_\_

**I. Client Information:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  Male  Female

In case of emergency, please notify:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please complete this section for others residing in the client's home:

Name	Date of Birth	Age	Gender	Relationship To Patient

**II. Insurance:**

Policy Holder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  Male  Female  
Insurance Company: \_\_\_\_\_ Authorization #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_  
Number of Sessions Authorized: \_\_\_\_\_ Co-pay: \_\_\_\_\_ Policy Holder/Subscriber id# \_\_\_\_\_  
Employer: \_\_\_\_\_ Job Title: \_\_\_\_\_  
If patient is a dependent, what is his / her relationship to policyholder: \_\_\_\_\_

**III. Optional Information:**

**Ethnic Background:**

- American Indian or Alaskan Native
- Asian or Pacific Islander
- African-American
- Hispanic
- Caucasian
- Other: \_\_\_\_\_

**Highest Education Level:**

- No High School
- Some High School
- High School Diploma
- Some College / Technical School
- Bachelor's Degree
- Master's Degree
- Doctorate

**IV. Educational / Occupational Status (check all that apply):**

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> Currently employed | <input type="checkbox"/> Full-Time  |
| <input type="checkbox"/> Self Employed      | <input type="checkbox"/> Part-Time  |
| <input type="checkbox"/> Homemaker          | <input type="checkbox"/> Student    |
| <input type="checkbox"/> Retired            | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Disability         |                                     |

**V. Health Status:**

Current or chronic medical issues: \_\_\_\_\_

Prior medications taken for emotional / substance abuse problems:

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Current medications taken for emotional / substance abuse problems:

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Other medications: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**VI. Mental Health:**

	Therapist / Facility	Date	Duration	Outcome
Prior Therapy	1)	1)	1)	1)
	2)	2)	2)	2)
Prior Hospitalization	1)	1)	1)	1)
	2)	2)	2)	2)

**VII. Problem Category: (please check all that apply):**

- |  |   |
|--|---|
| <input type="checkbox"/> Emotional Health              | <input type="checkbox"/> Abuse / Violence |
| <input type="checkbox"/> Substance Use / Abuse         | <input type="checkbox"/> Health Related   |
| <input type="checkbox"/> Suicide Risk                  | <input type="checkbox"/> Children         |
| <input type="checkbox"/> Marital / Relationship Issues | <input type="checkbox"/> Financial        |
| <input type="checkbox"/> Other Family Issues           | <input type="checkbox"/> Legal            |
| <input type="checkbox"/> Eating Disorder               | <input type="checkbox"/> Other _____      |

Please briefly describe why you are choosing to enter treatment at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_