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NEW CLIENT INFORMATION QUESTIONNAIRE

NAME _____ TODAY'S DATE _____
ADDRESS _____ BIRTH DATE _____

PHONE _____
SOC. SEC.# _____ HOME _____ WORK _____ CELL _____
CURRENT AGE _____ EMPLOYER _____
EMERGENCY CONTACT: OCCUPATION _____
Name _____ Relationship _____ Phone _____

SPOUSE/PARTNER _____ AGE _____ BIRTHDATE _____
ADDRESS _____ PHONE _____

HOME _____ WORK _____
SOC. SEC. # _____
EMPLOYER _____
OCCUPATION _____

LIST ALL OTHERS LIVING WITH YOU:

NAME	SEX	AGE/BIRTHDATE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HEALTH INSURANCE COVERAGE (LIST YOUR COVERAGE IF YOU WANT US TO BILL IT)

INSURANCE COMPANY (NAME, ADDRESS, PHONE)	NAME OF INSURED (POLICYHOLDER)	GROUP NUMBER
_____	_____	_____
_____	POLICYHOLDER DATE OF BIRTH: _____	
_____	POLICYHOLDER ID# _____	
_____	RELATIONSHIP OF POLICYHOLDER TO YOU _____	

PROVIDE THE SAME INFORMATION FOR ANY SECONDARY INSURANCE YOU HAVE:

BRIEFLY DESCRIBE YOUR REASONS FOR SEEKING HELP: _____

WHO SUGGESTED YOU CONTACT ME? _____

WHEN WERE YOU LAST EXAMINED BY A PHYSICIAN? _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

LIST ANY MAJOR HEALTH PROBLEMS FOR WHICH YOU CURRENTLY RECEIVE TREATMENT: _____

LIST ANY MEDICATION (including dosage) YOU ARE NOW TAKING: _____

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS WHICH APPLY TO YOU:

NERVOUSNESS	ALCOHOL USE	AMBITION
SHYNESS	SELF-CONTROL	SPACING OUT
SEPARATION	STRESS	MAKING DECISIONS
DRUG USE	HEADACHES	CONCENTRATION
ANGER	MEMORY	HEALTH PROBLEMS
SLEEP	SEXUAL ORIENTATION	RELATIONSHIP TROUBLES
RELAXATION	INSOMNIA	
LEGAL MATTERS	INFERIORITY FEELING	STOMACH TROUBLE
CHILDHOOD SEXUAL ABUSE	CAREER CHOICES	MY THOUGHTS
	NIGHTMARES	ANXIETY
ENERGY (Low or High)	APPETITE	CONSTANT WORRIES
LONELINESS	BEING A PARENT	OBSESSIVE THINKING
EDUCATION	FEARS	COMPULSIVITY
TEMPER	SUICIDAL THOUGHTS	PERFECTIONISM
CHILDREN	FINANCES	HOMICIDAL URGES
BOWEL TROUBLES	FRIENDS	PANIC ATTACKS
DEPRESSION	UNHAPPINESS	GAMBLING
SEXUAL PROBLEMS	WORK	HOARDING
DIVORCE	TIREDDNESS	

HAVE YOU EVER RECEIVED PSYCHIATRIC OR PSYCHOLOGICAL HELP OR COUNSELING OF ANY KIND? _____. IF SO, PLEASE LIST WHEN, WHERE, WHOM YOU SAW AND THE PURPOSE:

PLEASE ADD ANY ADDITIONAL INFORMATION WHICH YOU THINK MAY BE USEFUL

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE BRING IT TO YOUR FIRST APPOINTMENT.

YOUR SIGNATURE

DATE