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NEW CLIENT INFORMATION QUESTIONNAIRE

NAME_____ **TODAY'S DATE**_____

ADDRESS_____ **BIRTH DATE**_____

_____ **PHONE**_____ _____
HOME **WORK**

CURRENT AGE_____

EMERGENCY CONTACT: **EMPLOYER**_____

OCCUPATION_____

Name_____**Relationship**_____**Phone**_____

_____

SPOUSE/PARTNER_____ **AGE**____ **BIRTHDATE**_____

ADDRESS_____ **PHONE**_____ _____
HOME **WORK**

_____

EMPLOYER_____

OCCUPATION_____

_____

LIST ALL <u>OTHERS</u> 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)** **ID#** _____

_____ _____

_____ **POLICYHOLDER DATE OF BIRTH:** _____

_____ **POLICYHOLDER SOCIAL SECURITY #**_____

_____ **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	TIREDNESS	

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 RETURN IT PROMPTLY IN THE ENVELOPE PROVIDED.

_____ _____

YOUR SIGNATURE **DATE**