Date: / /

New Patient Information

Name: _____ Sex: _____ Birthdate: _____ Age: _____

Presenting Problems: (Check all that apply)

	None	Mild	Moderate	Severe
Tired or Fatigued	☐	☐	☐	☐
Tension or Anxiety	☐	☐	☐	☐
Sleep Disturbance	☐	☐	☐	☐
Arguing with Significant Other	☐	☐	☐	☐
Feelings of Guilt	☐	☐	☐	☐
Concentration / Attention Problems	☐	☐	☐	☐
Abuse or Related Problems	☐	☐	☐	☐
Marital Problems	☐	☐	☐	☐
Problems with Children	☐	☐	☐	☐
Sexual Concerns	☐	☐	☐	☐
Alcohol or Drug Use Problems	☐	☐	☐	☐
Physical Complaints	☐	☐	☐	☐
Memory Problems / Irrational Fears	☐	☐	☐	☐
Work-related Problems	☐	☐	☐	☐
Eating Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Anger	☐	☐	☐	☐
Obsessions or Compulsions	☐	☐	☐	☐
Suicidal Thoughts	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

What would you like to accomplish in your counseling?

Mental Health History: ☐ None

Have you received counseling in the past? ☐ Yes ☐ No
If yes, when, with whom, and for what reason?

Have you been hospitalized for a mental health issue? ☐ Yes ☐ No
If yes, when and for what reason?

Is there a family history of mental health problems or nervous problems? ☐ Yes ☐ No
If yes, please explain.

Medical History:

Who is your current Primary Care Physician? _____ Date of last visit: _____

Describe any present or past health concerns/problems, including any childhood traumas or surgeries.

List all medications and dosages you are currently taking.

Height: _____ Weight: _____ Recent weight gain or loss: _____ lbs. Appetite: _____

Substance Use/Abuse History:

	None	Past	Present	Frequency/Amount
Alcohol	☐	☐	☐	_____
Drugs	☐	☐	☐	_____
Nicotine	☐	☐	☐	_____
Caffeine	☐	☐	☐	_____

Have you received treatment for any of the above substances? ☐ Yes ☐ No
If yes, when, for what substance and for how long?

Do you have any family members with substance abuse problems? ☐ Yes ☐ No
If yes, list relationship and substance abused.

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Family/Social History:

Parent's marital status: ☐ Married ☐ Separated ☐ Divorced (# of times: _____)
If married, how would you describe the quality/satisfaction of their marriage?

Describe your relationship with your father and mother.

Sibling's names:		Age:	Marital Status	Occupation
_____	M / F	_____	M / S / D	
_____	M / F	_____	M / S / D	
_____	M / F	_____	M / S / D	
_____	M / F	_____	M / S / D	
_____	M / F	_____	M / S / D	

Describe your relationship with your siblings.

Describe your childhood/adolescent years. (Attitude, feelings, like, dislikes, etc.)

Is there any history of verbal, physical, or sexual abuse in your family? ☐ Yes ☐ No
If yes, please describe.

Describe your current family relationships and living arrangements.

List and describe your support system of family and friends.

Marital History:

☐ Single ☐ Married (# of years: _____) ☐ Separated (Date: _____) ☐ Divorced (Date: _____)

How many times have you been married and what was your age and your partners?
If divorced, please give reason.

If married, how would you describe the quality/satisfaction of your present marriage?

How many children do you have? Natural: _____ Adopted: _____

Child's Name	Age	Marriage Status	City/State

How would you describe your relationship with your children?

Educational/Employment History:

What is the highest grade you completed in school? _____ GED? ☐ Yes ☐ No

Other education/training? _____ Occupation/Vocation: _____

Current Employer: _____ How long? _____

Number of jobs in the last 5 years: _____

What career/educational plans do you have?

Legal History:

Number of arrests: _____ Number of substance-related arrests: _____

Number of OUIL, DUIL, or DWI arrests: _____

Nature of other arrests:

Other legal concerns:

Religious/Spiritual Background:

List any formal religious affiliation.

Please describe your involvement.

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