



NEW CLIENT INFORMATION SHEET – Adult Form

Name: _____ Date of Birth: ___/___/_____ Age _____ Today’s Date _____

MEDICAL

Are you currently under a doctor’s care? (check one or more) No psychiatrist family physician other medical doctor

Name of Doctor(s): _____

For what illness(s) are you being treated? _____

Current Medications (prescriptions and over-the-counter): _____

Date of Last Doctor’s Visit: _____ Date of Last Physical Exam: _____ Status of Health: _____

Indicate recent changes in (check all that apply): weight appetite sleeping patterns mood

Please list any *major* illnesses, injuries, health problems you have had: _____

If you have had previous counseling or psychiatric care, please indicate when (approximate) and with whom: _____

MARRIAGE AND FAMILY Never Married Engaged Married Separated Divorced Widowed
 Non-married, committed relationship

If married, number of years: _____ Length of relationship prior to marriage, or if not married: _____

Number of Your Prior Marriages: _____ (Approximate Dates) _____

Number of partner’s prior marriages: _____ (Approximate Dates) _____

Names and ages of your children in your care _____ Not in your care _____

Names and ages of stepchildren in your care _____ Not in your care _____

YOUR EDUCATION AND EMPLOYMENT

Education Level/Credential: _____

Employment Status: Employed Full-time Homemaker
 Seeking Work Retired Student

Current Employer: _____

Job title: _____

YOUR SPOUSE/PARTNER’S EDUCATION AND EMPLOYMENT

Education Level/Credential: _____

Employment Status: Employed Full-time Homemaker
 Seeking Work Retired Student

Current Employer: _____

Job title: _____

RELIGIOUS AND SPIRITUAL

Do you consider yourself spiritual _____? religious _____? Comment? _____

Do you currently express this spirituality through religious practice? Yes No Comment? _____

Denominational Preference: _____ Faith/Denomination in which you were reared: _____

Current Congregation: _____

How active are you? None Some Very

SELF-DESCRIPTION CHECKLIST: Please check each term below which describes your current feelings.

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Fatigued | <input type="checkbox"/> Puzzling ideas | <input type="checkbox"/> Loss of love |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Confused | <input type="checkbox"/> Suicidal | <input type="checkbox"/> Resentful | <input type="checkbox"/> Loss of control |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Dangerous | <input type="checkbox"/> Unhappy | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Jealous | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Outgoing | <input type="checkbox"/> Distrustful | <input type="checkbox"/> Indifferent | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Isolated | <input type="checkbox"/> Lonely | <input type="checkbox"/> Apathetic | <input type="checkbox"/> Work stress | <input type="checkbox"/> Fretful |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hurt | <input type="checkbox"/> Poor sex drive | <input type="checkbox"/> Unwelcome thoughts |
| <input type="checkbox"/> Marital stress | <input type="checkbox"/> Spiritual worries | <input type="checkbox"/> Numb | <input type="checkbox"/> Loss of faith/God | |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Bereaved | <input type="checkbox"/> Abused | <input type="checkbox"/> Loss of faith/Self | |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Guilty | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Loss of faith/Other | |
| <input type="checkbox"/> Violent | <input type="checkbox"/> Ashamed | <input type="checkbox"/> Worried | <input type="checkbox"/> Loss of meaning | |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Cheerful | <input type="checkbox"/> Panic | <input type="checkbox"/> Loss of self respect | |

YOUR CHILDHOOD FAMILY

Person's Name	Age or Year If Deceased	Marital Status	Education	Occupation	Quality of Your Relationship	Mental/Physical Illness
Mother:						
Father:						
Step-Mother:						
Step-Father:						
Other Primary Care Giver(s):						
Siblings:						