

NEW CLIENT BIOGRAPHICAL INFORMATION		Date:
Name:	Date of Birth:	Age:
Address:	City, State, Zip:	
Phone: (Home)	(Work)	(Cell)
Would you prefer to be contacted at <input type="checkbox"/> home <input type="checkbox"/> work <input type="checkbox"/> cell?		
Email Adress:		
May we add you to our email list <input type="checkbox"/> Yes <input type="checkbox"/> No?		
Occupation:		
Education:		
Employer:		
Address:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Engaged <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Co-Habiting		
Squeeze's Name:		Age:
Occupation:		Employer:
Names & Ages of Children:		
Number of Marraiges & Length of Each:		
Religious Practice As A Child:		As An Adult:
Name of Current Place of Worship:		Clergy's Name:
Address:		Phone:
May we contact your place of worship about our services (counseling, groups, seminars, etc.)?		
<input type="checkbox"/> Yes but don't mention my name <input type="checkbox"/> Yes and you can mention my name <input type="checkbox"/> No way!		
Emergency Contact:		
Phone: (Home)		(Work)
(Cell)		
Who referred you, or suggested that you come to seek counseling? Check all that apply.		
<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Employer <input type="checkbox"/> Other		
Please summarize the issues for which you are seeking help. If there is more than one reason, rank them in order.		
1)	2)	
3)		
Circle the number that represents the severity of your concerns.		
Not Severe	1	2
	3	4
	5	Very Severe

Family of Origin (Parents, Siblings):

Name	Age	Relationship

Does anyone in your family suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental health issue? Please explain.

**MEDICAL/EMOTIONAL HISTORY**

Physicians Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last Physical: \_\_\_\_\_

Please list any medical treatments & operations within the last year:

Please list all current illnesses: (allergies, ulcers, tensions, back problems, sking disorders, etc.)

Please list any prescription medications you have taken within the last six months, circle current medications:

Have you had any prior personal counseling? \_\_\_\_ Yes \_\_\_\_ No (If yes, please list therapists, dates, and addresses)

Have you ever been hospitalized for an emotional disorder, eating disorder or chemical dependency, etc.?

\_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, please list hospital, doctor's name and dates with a brief explanation)

Have you ever considered or attempted suicide? Please explain briefly.

Have you ever been sexually, physically, or emotionally abused? If so, by whom and how long ago?

Check any of the following problems that apply to you:

- |       |                           |       |                             |       |                     |
|-------|---------------------------|-------|-----------------------------|-------|---------------------|
| _____ | Headaches                 | _____ | Dizziness                   | _____ | Fainting spells     |
| _____ | Heart Palpitations        | _____ | Poor appetite               | _____ | Bowel disturbances  |
| _____ | Fatigue                   | _____ | Insomnia                    | _____ | Nightmares          |
| _____ | Sedative use              | _____ | Problem with alcohol        | _____ | Tension/anxiety     |
| _____ | Panic attacks             | _____ | Tremors                     | _____ | Depressed           |
| _____ | Thoughts of suicide       | _____ | Drug use                    | _____ | Difficulty relaxing |
| _____ | Difficulty making friends | _____ | Lack of enjoyment in life   | _____ | Sexual problems     |
| _____ | Difficulty keeping a job  | _____ | Difficulty making decisions | _____ | Legal Matters       |
| _____ | Inferiority feelings      | _____ | Poor home environment       | _____ | Financial problems  |
| _____ | Educational difficulties  | _____ | Feelings of loneliness      | _____ | Anger               |
| _____ | Problems with children    | _____ | Self-control problems       | _____ | Memory problems     |
| _____ | Career Choices            | _____ | Parenting issues            | _____ | Distractability     |
| _____ | Binge/Vomit/Laxative Use  | _____ | Loss of time/blackouts      | _____ | Hyperactivity       |
| _____ | Difficulty sitting        | _____ | Compulsive behavior         | _____ | Marital problems    |
| _____ | Racing Thoughts           | _____ | Divorce                     | _____ | Separation          |

Briefly list what you think are your personal strengths and weaknesses. Think in terms of your personality, work habits, intellectual capabilities, and other skills or talents.

Strengths

Weaknesses

### CREDIT CARD INFORMATION

TYPE NAME ADDRESS

NUMBER EXP

### MARKETING INFORMATION

How did you hear about my services?

What prompted you to choose my services?

\_\_\_ Price \_\_\_ Location

\_\_\_ Friend \_\_\_ Philosophy of Counseling

\_\_\_ Reputation of Center \_\_\_ Reputation of Counselor

\_\_\_ Other \_\_\_\_\_

What type of seminars interest you?

\_\_\_ Relationships \_\_\_ Depression \_\_\_ Other: \_\_\_

\_\_\_ Anger \_\_\_ Sexual Abuse \_\_\_

\_\_\_ Marriage \_\_\_ Spiritual Growth

\_\_\_ Pre-marriage \_\_\_ Parenting