

# Bridging XVII Counseling Center

## New Client Information Sheet

*\*This Form is Confidential\**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

Date of birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Referred by: \_\_\_\_\_

- May I have your permission to thank this person for the referral?

Yes  No

- If referred by another clinician, would you like for us to communicate with one another?

Yes  No

Person(s) to notify in case of any emergency:

\_\_\_\_\_ Name

\_\_\_\_\_ Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:

Client Signature: \_\_\_\_\_



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Do you smoke? **YES NO** If Yes, how much per day? \_\_\_\_\_

Do you consume Caffeine? **YES NO** If Yes, how much per day? \_\_\_\_\_

Do you drink alcohol? **YES NO**  
If Yes, how much per day/week/month/year? \_\_\_\_\_

Do you use any non-prescription drugs? **YES NO**  
If Yes, what kinds and how often? \_\_\_\_\_

Have you ever been in trouble or in risky situations because of your substance use? **YES NO**

Previous medical hospitalizations (Appropriate dates and reasons): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Previous psychiatric hospitalizations (Appropriate dates and reasons): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? **YES NO** (Please list approximate dates and reasons):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Height \_\_\_\_\_ Weight (if applicable) \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Sexual & Gender Identity:  Heterosexual  Lesbian  Gay  Bisexual  
 Transgender  Asexual  In Question  Other

Racial/Ethnic Identity:

African/African-American/Black  Latino/Latino-American  
 Bi-Racial/Multi-Racial  American Indian/Alaska Native  
 Middle Eastern/Middle Eastern-American  White/European-American  
 Asian/Asian-American/Asian Pacific Islander  
 Not listed

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### FAMILY:

How would you describe your relationship with your mother? \_\_\_\_\_

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How would you describe your relationship with your father? \_\_\_\_\_

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Are your parents still married? \_\_\_\_\_ If they divorced, how old were you when they separated or divorced, and how did this impact you?

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Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life:

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How many sisters do you have? \_\_\_\_\_ Ages? \_\_\_\_\_

How many brothers do you have? \_\_\_\_\_ Ages? \_\_\_\_\_

How would you describe your relationships with your siblings?

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### RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? \_\_\_\_\_ How Long? \_\_\_\_\_

Relationship Satisfaction: POOR EXCELLENT  
1 2 3 4 5 6 7

Married/Life Partnered? \_\_\_\_\_ How Long? \_\_\_\_\_

Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships \_\_\_\_\_

Do you have Children? \_\_\_\_\_ If YES, how many and what are their ages: \_\_\_\_\_

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Describe any problems any of your children are having:

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List the names and ages of those living in your household:

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Please briefly describe any history of abuse, neglect and/or trauma:

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Current level of satisfaction with your friends and social support:

POOR EXCELLENT  
1 2 3 4 5 6 7

Please briefly describe your coping mechanisms and self-care:

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Is spirituality important in your life and if so please explain:

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Briefly describe your diet and exercise

patterns: \_\_\_\_\_

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### EDUCATION & CAREER

High School/GED\_\_\_ College Degree\_\_\_ Graduate Degree (or Higher)\_\_\_

Vocational Degree\_\_\_

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What is your current employment?

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Employment Satisfaction:      POOR                      EXCELLENT  
   1   2   3   4   5   6   7

Any past career positions that you feel are relevant?

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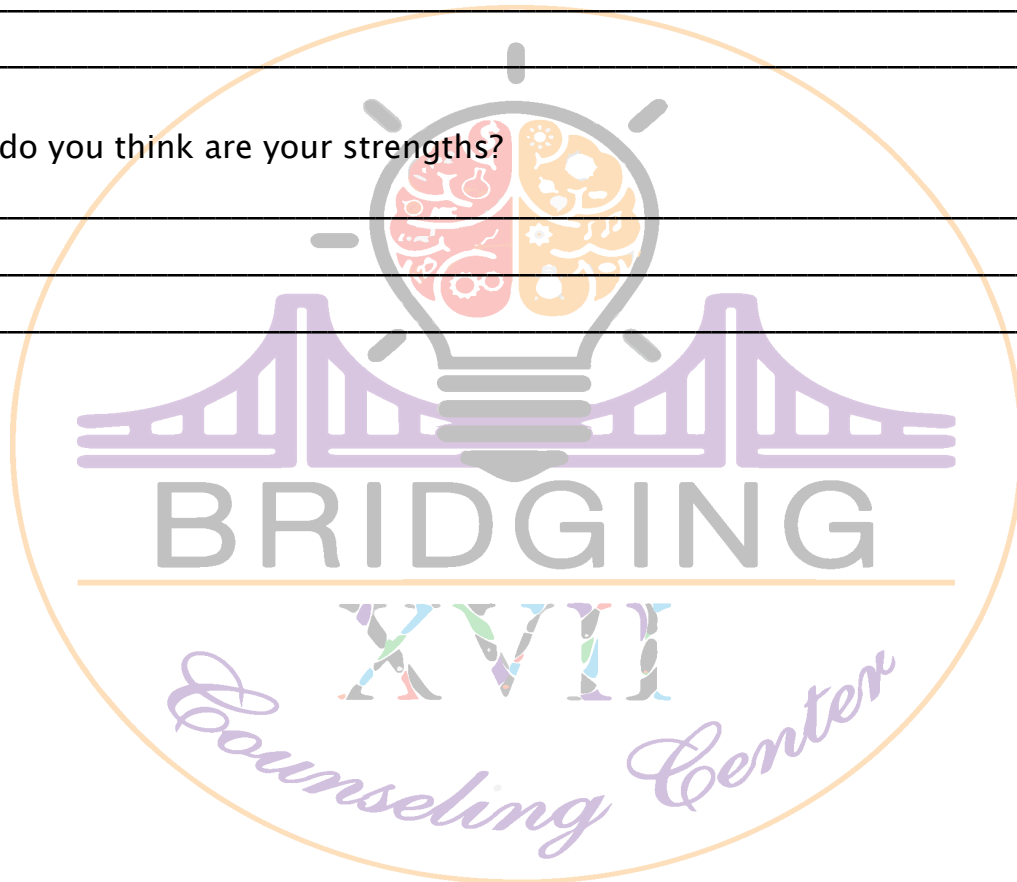
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What do you think are your strengths?

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PLEASE CHECK ALL THAT APPLY & *CIRCLE* THE MAIN PROBLEM:

Difficulty With:	Now	Past		Difficulty With:	Now	Past		Difficulty With:	Now	Past
Anxiety				People in General				Nausea		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/ Partnership				Dizziness		
Panic				Friends				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Swearing		
Loss of Memory				Sexual Concerns				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in Joints		
Trusting Others				Domestic Violence				Allergies		
Communicating w/ Others				Homicidal Ideations				Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Suicidal Ideations				Speak w/o thinking		
Caffeine				Sleeping to Much				Waiting your turn		
Frequent Vomiting				Sleeping too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply)

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalizations	
Suicide		Learning Disabilities		Nervous Breakdown	

Any additional information you would like to include:

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