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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Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

How long do you expect to be in therapy in order to accomplish these goals?

_____

***The Following information will help guide your treatment. Please try to fill out as much as you are comfortable disclosing. ***

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Prescribing Doctor

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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
__Bi-Racial/Multi-Racial
__Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander
__Not listed
__ Latino/Latino-American
__American Indian/Alaska Native
__White/European-American

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FAMILY:

How would you describe your relationship with your mother? _____

_____

_____

How would you describe your relationship with your father? _____

_____

_____

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

_____

_____

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:

_____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings?

_____

_____

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:

_____

_____

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

_____

_____

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

_____

_____

_____

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:

_____

_____

_____

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

_____

_____

_____

Briefly describe your diet and exercise

patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree (or Higher)___
Vocational Degree___

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What is your current employment?

_____

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

Any past career positions that you feel are relevant?

_____

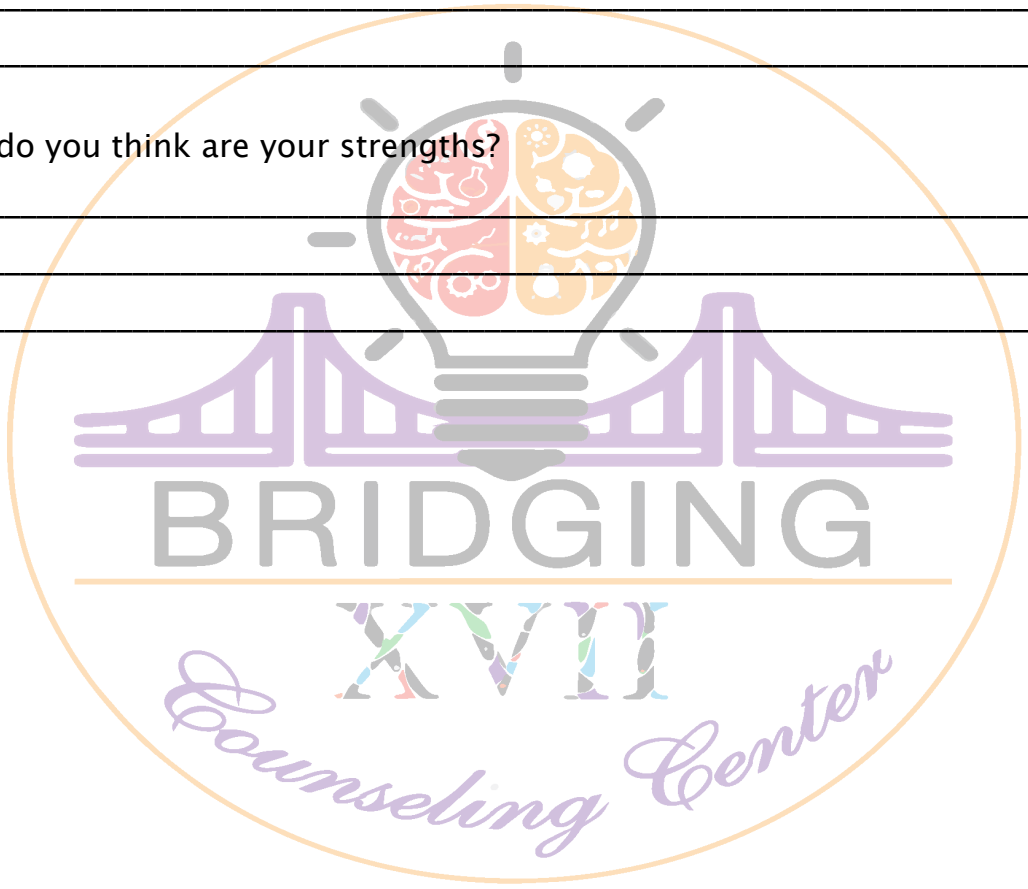
_____

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:

_____

_____