

NEW CLIENT BACKGROUND

To allow us to best serve you, please complete this form with as much accuracy and honesty as possible.

Last Name:First:

Date of Birth:.....Age: Gender:.....

YOUR PERSONAL HISTORY

Place of birth: _____

Please list previous places you have lived: _____

Height: _____ Weight: _____ Last Physical Exam : _____

Primary Care Physician: _____ Phone _____

Psychiatrist: _____ Phone _____

Marital Status: Married / Divorced / Widowed / Separated / Single / Living with Partner

Number of times married: _____ Number of Children: _____

Names and ages of children _____

Where are children living now? _____

Please describe **your** feelings regarding your current situation: _____

YOUR FAMILY HISTORY

Please list significant family members (parents, siblings and others) their relationship to you and their approximate age.

Note alongside if applicable: SA= substance abuse, MI = mental illness,
VS = violence to self, VO = violence to others

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

With whom do you currently reside? _____

Please give the names of family members, **including you**, who are currently, or have in the past, under the care of a mental health professional and or substance abuse treatment program:

<u>NAME</u>	<u>PROBLEM</u>	<u>SEEN WHEN AND WHERE</u>

- Have you ever deliberately hurt yourself? Yes / No
- Have you ever attempted suicide? Yes / No
- Have you ever assaulted another person? Yes / No
- Do you have a history of fire setting? Yes / No
- Do you have a history of animal cruelty? Yes / No

CURRENT PHYSICAL HEALTH

<u>Current health problems</u>	<u>By whom are you being treated?</u>

Any Known Allergies: _____

Current Medications: _____

Are you compliant with your prescribed medications? Yes /No Not Applicable

Previous Significant Health Problems (Illnesses and surgeries):

Previous Hospitalizations (Medical and psychiatric):

SUBSTANCE USE INFORMATION

Do you drink regular coffee? Yes/ No. How many cups a day? _____

Do you smoke? Yes / No. How many a day? _____

Do you drink alcohol? Yes / No. How much per week? _____

Do you use other drugs? Yes / No. Name _____

Date of last use (drugs or alcohol) _____

SCHOOL / EDUCATION / RELIGIOUS HISTORY

Please describe your educational history: Highest grade completed, certificates, training

Military Service: Yes / No Branch: _____

Discharge Type Honorable / Dishonorable / Medical

Current Occupation: _____

Current Employer: _____

Please list the types of jobs you have held in the past: _____

Please list religious affiliations you have or have had in the past: _____

List any cultural beliefs that may interfere with your treatment: _____

PEER INTERACTION AND SELF PERCEPTION

In the past few years have you had difficulty getting along with others? _____

What feedback do you get about yourself from others? _____

How do you generally handle your anger? _____

Has your anger even gotten you into trouble, if so how? _____

What do you consider your character strengths?

What do you consider your character weaknesses?

Do you have a best friend? _____

How do you unwind / relax? _____

Do you have a hobby? _____

What do you do for fun? _____

PROBLEM AREAS

Circle the areas in which you are experiencing difficulties at this time.

- | | | | |
|----------------------|--------------------|--------------------|---------------------|
| Acute Pain | Elevated Mood | Marital Problems | Revengeful Thoughts |
| Alcohol Use | Energy Level | Memory | Seeing Things |
| Ambition | Family | Mood Swings | Self Control |
| Anger | Fears | Motivation | Self Mutilation |
| Appearance/ Health | Finances | Nervousness | Separation |
| Appetite | Friends | Nightmares | Sexual Problems |
| Bowel Troubles | Gambling | Occupational | Shyness |
| Career Choice | Habits | Panic | Sleep |
| Chronic Pain | Hearing of Voices | Paranoia | Stomach Trouble |
| Concentration | History of Abuse | Parenting | Stress |
| Decision Making | Impulsive Behavior | Racing Thoughts | Study Habits |
| Depression | Inferiority | Relationships | Suicidal Thoughts |
| Distressing Thoughts | Legal Issues | Relaxation | Tiredness |
| Drug Use | Loneliness | Repeating Thoughts | Unhappiness |
| Eating Habits | Love / Affection | Resentment | Weight |

PRESENTING PROBLEM:

If there is one, please describe the **specific** problem that has brought you to our office:

Describe your current feelings about the problem: _____

What steps have you already taken to correct the problem? _____

Please give any other information that you feel is relevant: _____

How do you want us to help you? _____

If your family is aware, what is their attitude towards your problem?

If applicable, describe benefits obtained through previous treatment:

LEVELS OF COPING SKILLS

On A Scale Of 1 – 10 With 10 Being The Best,

What Is Your Current Level Of Coping? _____

What Is Your Highest Level Of Coping In The Past Year? _____

Signature _____ Date _____