## New Client Information & Psychosocial History

**Legal Name and Name You Go By:**_____ **DOB:**_____
**Address:**_____
**Phone:**_____ **Email**_____

**Presenting Problem(s)**
**Please state the reason and/or symptoms that brought you here today:**

_____
_____
_____
_____

**Check all symptoms you have been experiencing:**
( ) anxiety ( ) depression ( ) lack of motivation ( ) sleep problems
( ) anger ( ) fatigue ( ) moodiness ( ) seasonal mood changes
( ) aggressive behavior ( ) fears or phobias ( ) negativity
( ) appetite changes- if yes then *circle either*- increased or decreased
( ) panic symptoms ( ) attention problems ( ) impulsive behavior
( ) procrastination ( ) compulsive behaviors ( ) irritability ( ) obsessive thinking
( ) suicidal thoughts or actions ( )school/work problems ( ) relationship problems

**Describe symptoms and how long you've experienced them:**

_____
_____
_____

**List All Current Medications and Prescribers (Psychiatric provider, Primary Care, etc):**
MEDICATION NAME / DOSAGE / REASON FOR TAKING

_____
_____
_____

**Have you ever had counseling** Yes____ No____
Dates of treatment: _____ Provider:_____
Reason:_____
_____

**H**ave **you ever been hospitalized for psychiatric reasons**? Yes____ No____
Dates of treatment: _____ Provider:_____
Reason:_____
_____
_____

**Abuse/Trauma:** Have you ever experienced any physical, mental, or sexual abuse?_____
Do you ever have nightmares, flashbacks or feel like you are "re-living" the traumatic events? Explain.

_____
_____
_____

## Medical History

**Current medical conditions** *(diabetes, fibromyalgia, high blood pressure, etc.):*

_____
_____
_____

**How much alcohol are you consuming in a week, including beer and wine?**

_____

**Please list all recreational drug use past and present-** *Data is used for health purposes & for therapeutic information. You are not judged and I am not the police - please describe* use: (types of drugs, frequency, and age of onset of use.) If you have never used, indicate as such.

_____
_____
_____

## Family History

**Please list mental health or substance use issues for biological family members, if known or suspected:** (*bipolar, depression, anxiety, schizophrenia, ADHD, etc), i.e. "Mom has Bipolar Disorder"*

_____
_____
_____

**Current Relationship Status: ____**Married ____ Divorced ____Separated _____Single
____ Widowed ____Domestic Partnership _____Dating, but no serious relationship

**Years in current relationship**? _____

**Do you have any children? ___** Yes____ No
If ***yes***, Names and Ages: _____
_____

**How far did you get in school, i.e. finished high school, some college, etc. Area of study?**

_____

**Have you had any legal difficulties?** (*this is asked for therapeutic reasons also)* __Yes __No
*If **yes**, please describe*:_____

**Please Read and Initial the following statements related to Policy (HIPAA, Cancellation, etc):**

_____ I understand that I am consenting (for myself if 16+ years old, or for my child) for a counseling/therapy intake session with **Jennifer Strickland, a Licensed Professional Counselor and Mental Health Service Provider.**

_____ I am aware of My Rights and Responsibilities related to **HIPAA** and a copy of the **Privacy Policies** will be given to me, if requested (located on intake clipboard).

_____ I am aware of the **24 hour (or 1 business day) Cancellation Policy**. I am aware that I will be charged and **Responsible for 80% of my Session Fee,** without 24 hour notice of cancellation.

**Completed by: _____ Date:_____**
(Signature of Client, Age 18 or Older)

**Guardian Signature (if applicable): _____**

**Date: _____**