Name_____
Address_____
_____
Home Phone_____ Wk Phone_____
Cell Phone_____ Emer Contact_____

NEW PATIENT REGISTRATION

Describe your reason(s) for seeking treatment at this time (include date or month/year problem started)

Was there an event which made these issues or problems surface? If yes, please describe.

What result do you expect from treatment?

Please indicate and rate severity (1-4) of the following issues or problems you would like to work on in treatment: (1=low severity, 4=high severity)

____depression
____anxiety
____controlling stress
____loss of a loved one
____problems at school
____problems at work
____lack of friends
____loneliness
____problems coping
____abuse/victimization
____financial problems
____legal matters
____marriage/relationship issues
____sexuality/sexual issues
____family conflict
____behavioral problems
____eliminating a drug/alcohol habit
____eliminating another habit (overspending, overeating, gambling, etc)

Please indicate how the issues for which you are seeking treatment are affecting the following areas of your life (1 – 5 or NA)

____marriage/relationship
____family
____job/school performance
____friendships
____eating habits
____sleeping habits
____sexual functioning
____ability to concentrate
____ability to control temper
____financial situation
____physical health
____anxiety level/nerves
____mood
_____spirituality

Do you serve in the military? If yes, type of discharge._____ Dates of service_____ Branch of service_____

FAMILY HISTORY

Are your parents still living? Parents divorced?

Do you have brothers and/or sisters? If yes, please list their in order from eldest to youngest including yourself.

If you have children, please list their names and ages, beginning with the eldest.

Are any of your children adopted?

What is your marital history? Please indicate names as you tell me this.

PERSONAL MEDICAL HISTORY

Do you have any allergies to food/medications? If yes, please describe.

Please list any prescription medications you currently use (name, dosage, frequency).

Please list any over the counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc (name, dosage, frequency).

Please list hospitalizations from past medical/surgical illnesses (Include name of hospital, dates of confinement, illness/procedure).

When was your last physical examination? (Include date, doctor's name)

Were there any significant findings?

Are you currently being treated for any medical conditions? If yes, please list.

Describe your typical eating behavior.

What did you have to eat yesterday (or today, if this is evening)? (If you can't remember, keep track here of what you eat today or tomorrow. Try not to change just because you are keeping track..) Include snacks.

Do you experience any of the following: (Please check all that apply)

____double or poor vision
____difficulty hearing
____fainting
____blackouts
____convulsions
____paralysis
____dizziness
____headaches
____thyroid problem
____cough or wheezing
____chest pain
____shortness of breath
____palpitation or heart fluttering
____swelling of hands or feet
____weight gain or loss
____unusual excessive thirst/dry mouth
____indigestion, gas, heartburn
____stomach pain
____diarrhea or constipation
____vomiting/vomiting blood
____blood in stool
____change in appetite or eating habits
____trouble sleeping
____sexual problems
____problems with memory, thinking, concentration or attention
____weakness or tiredness
____joint pain
____lumps anywhere on body – please specify location

Have you ever used drugs or alcohol? If yes, please describe.
substance amount frequency last taken
_____
_____
_____

Do you have a history of blackouts, seizures or withdrawal symptoms? If yes, please describe.

Have you ever received mental health or substance abuse treatment before?
If yes, please describe.

Type of treatment	Provider name	First seen	Last seen

If applicable, please list name of medication and dosage taken for condition.

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or to the people close to you? (i.e., gambling, spending, sexual behavior, use of food, exercise, television watching, hoarding, checking, counting, washing, illness-related, thoughts of harming someone, use or fear of use of obscene language, etc)

Have you ever been arrested for a crime?

Life Style Habits
Describe your use of the following:

	Amount currently using	**Most ever used**	**When/How long ago?**
coffee (cps/day)			
caffeinated soft drinks			
cigarettes (pks/day)			
alcohol (drnks/day)			
cigars/pipes (per day)			

Current exercise

Type	**Frequency**

Hrs/week spent at work:

Describe your past and current religious orientations. (The purpose behind this question is to match my therapeutic approach to your religious preferences as closely as possible without a loss of integrity.)

Indicate how ;you would feel about having counseling "homework" during the week, in general.

Indicate, specifically, how you would response to each of these types of homework:
L=like DM=don't mind R=reluctant WD=won't do

_____reading exercises _____affirmations
_____writing in a journal _____meditation _____watching videos
_____keeping a list or diary _____exercise/eating changes
_____couple/family talks or _____massage

Are there any therapeutic approaches you know of which you would object to?

Hoe did you learn of my counseling practice?

What caused you to choose me rather than another counselor?

Have you undergone counseling of any sort before? If so, did you consider it successful? Why or why not?

Have you read self-help books or watched self-help videos or TV shoes in the past? If so, what titles do you remember? Do you feel they were helpful?

Do you expect therapy to be of short duration, designed to solve the immediate problem at hand in an efficient manner, or would you expect therapy to take some time, examining childhood and personal issues which may not seem to be immediately relevant? Of, if something else, describe that.

Is there anyone in your family who doesn't know you're in counseling and whom you would prefer did not know?

What is the highest educational level you have attained?

FAMILY MEDICAL HISTORY

Has anyone in your family had a serious medical illness? If yes, explain.

Has anyone in your family had a psychiatric (nervous or mental) illness? If yes, please explain.

If yes, what type of treatment if any did they receive?

Has anyone in your family had a substance abuse problem? If yes, explain.

May I contact and exchange information with your primary care physician to coordinate your care?

What do you consider to be your most significant strengths?

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize release of any information, including that related to psychiatric, drug and alcohol, or HIV related issues, necessary for case review and quality improvement procedures.

_____

Client

_____

Therapist

_____

Minor's Name

I give permission for the treatment of the above minor, if applicable.

_____

Client