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Date: _____

NEW CLIENT REGISTRATION

Name: _____ Age: _____ Sex: _____

Address: _____ SS#: _____

City, State, Zip: _____ Date of birth: _____

Home phone: _____ May I leave a message? Y N

Cell phone: _____ May I leave a message? Y N

Person responsible for bill: _____ Relationship: _____

Address: _____ Phone: _____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____

Address: _____

Work phone: _____ May I leave a message? Y N

INSURANCE INFORMATION:

Name of Insured: _____ Medical ID#: _____ DOB: _____

Primary Insurance Company: _____

Address: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

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Primary Insurance Company: _____

Address: _____ Phone: _____

Subscriber ID#: _____ Group #: _____

MEDICAL AND REFERRAL INFORMATION:

Name of Physician: _____ Phone: _____

Referred by: _____ Relationship? _____

HOUSEHOLD INFORMATION:

Spouse/Partner Name: _____

Employer: _____ Work Phone: _____

Others in Home:	Gender	Age	Relationship to You
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT:

Emergency contact: _____Relationship: _____

Address: _____

Home Phone: _____Work Phone: _____

FAMILY MEDICAL HISTORY:

	Living?	Age:	Illnesses or Cause of Death:
Father:	Y N	_____	_____
Mother:	Y N	_____	_____
Brother/Sister:	Y N	_____	_____
Brother/Sister:	Y N	_____	_____

MAIN PROBLEMS:

Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1----------2----------3----------4----------5----------6----------7----------8----------9----------10

No Problem	Mild Problem	Moderate Problem	Severe Problem	Couldn't Be Worse

	Rating:
1. _____	_____
2. _____	_____

3. _____ _____

Briefly describe what motivated you to seek therapy at this time (rather than some time earlier or later): _____

_____

What personal strategies have you previously used to try to remedy these problems?

_____

_____

HEALTH / MEDICAL ISSUES:

1. Do you have any serious medical conditions? No Yes (If yes, please describe)

_____

2. How would you rate your overall health? Excellent Good Fair Poor

3. Please list any medication (including dosages) that you are taking: _____

_____

4. How many: Visits to physician in past yr: _____ Sick days in past yr: _____

Therapy sessions, ever: _____ Cigarettes: Packs/day: _____

Alcohol: Drinks/day: _____ Caffeine: Cups/day: _____

5. Mark all that have resulted from your use of alcohol/drugs:

traffic ticket/violation fight with a friend financial problems physical violence

ruined a relationship blackouts work or school problems

CURRENT STRESSFUL EVENTS:

Listed below are some of the sources of stress that clients sometimes feel. Please circle the number that represents the amount of stress you currently feel in each area. (1=very little stress, 10=very high stress)

	Very little stress									Very high stress
1. Work or School	1	2	3	4	5	6	7	8	9	10
2. Personal Relationships	1	2	3	4	5	6	7	8	9	10
3. Family of Origin Issues	1	2	3	4	5	6	7	8	9	10

4. Parenting Responsibilities	1	2	3	4	5	6	7	8	9	10
5. Financial Concerns	1	2	3	4	5	6	7	8	9	10
6. Legal Concerns	1	2	3	4	5	6	7	8	9	10
7. Health Concerns	1	2	3	4	5	6	7	8	9	10
	Very little stress									Very high stress
8. Sexual Concerns	1	2	3	4	5	6	7	8	9	10
9. Self-esteem	1	2	3	4	5	6	7	8	9	10
10. Body Image	1	2	3	4	5	6	7	8	9	10
11. Grief / Recent Losses	1	2	3	4	5	6	7	8	9	10

BACKGROUND INFORMATION

Education History

Highest grade or degree completed in school: _____

Any difficulties with learning? _____

In my family, there is a history of (mark all that apply):

alcoholism	physical abuse
sexual abuse	emotional abuse
eating disorders	substance abuse (other than alcohol)
depression	anxiety
suicide attempts	hospitalization for psychiatric reasons
completed suicide	medication for psychiatric reasons

Are you in an abusive relationship?	Yes	No	Somewhat
Have you ever had an unwanted sexual experience?	Yes	No	Somewhat
Have you tried harming yourself in the past?	Yes	No	Somewhat
Have you harmed others in the past?	Yes	No	Somewhat

FEELINGS / SYMPTOMS

Please place a check mark beside the following feelings or symptoms that have been present for you in the last two weeks and place two check marks next to those items that are most pronounced for you.

____ Change in appetite
____ Significant weight gain
____ Significant weight loss
____ Feel agitated or restless
____ Feel slowed down or sluggish
____ Feel guilty a lot
____ Headaches
____ Racing Heart
____ Sweating
____ Shortness of breath
____ Fear of choking
____ Chest pain

____ Unable to concentrate
____ Withdrawing from other people
____ Withdrawing from your usual activities
____ Thoughts of death or dying
____ Thoughts of suicide
____ Intentions of suicide
____ Loss of energy
____ Feel hopeless about the future
____ Feel irritable
____ Depressed mood
____ Feel very angry at others
____ Trouble controlling your temper
____ Thoughts of harming someone else
____ Intentions of harming someone else
____ Hearing voices
____ Seeing things others don't see
____ Easily distracted
____ Disorganized
____ Procrastinate often
____ Impatient
____ Unhappy with weight/appearance
____ Loss of close relationship
____ Wonder whether to stay in a relationship
____ Purposely cut or hurt your body
____ Feel overwhelmed by your emotions
____ Sudden shifts in mood
____ Sleep problems
____ Food Bingeing
____ Food Purging
____ Difficulty making decisions
____ Difficulty finishing projects
____ Nausea
____ Dizziness
____ Fear of losing control
____ Fear of dying
____ Numbness
____ Chills or hot flashes
____ Feel detached from self
____ Muscle tension
____ Unwanted repetitive thoughts
____ Unwanted repetitive habits
____ Spending money excessively
____ Drinking excessively
____ Taking risks you regret later
____ Afraid of rejection
____ Easily influenced by others
____ Feelings get hurt easily
____ Have trouble expressing feelings
____ Have difficulty trusting others
____ Afraid of making mistakes
____ Feel nobody understands you
____ Feel talked about or make fun of
____ Feel like you don't have close friends
____ Feel inferior
____ Feel empty
____ Feel anxious
____ Distressing dreams
____ Body Aches/Pains
____ Unable to enjoy life
____ See no future
____ Worry a lot
____ Menstrual problems

WORST AND BEST TIMES IN LIFE

WORST TIME IN LIFE (Please briefly describe) _____

_____

_____

Who helped you through it? _____

BEST TIME IN LIFE (Please briefly describe) _____

_____

_____

What have you done that you are MOST PROUD OF? _____

_____

What are your STRENGTHS (how do you cope) when times are hard? _____

_____

_____

_____

Thank you for completing this questionnaire.