NEW CLIENT INFORMATION FORM
Choices Gwinnett

Today's Date: _____

Client's Name: _____

Spouse's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Birthday/Age: _____

Emergency Contact: _____ Phone Number: _____

Relationship_____

Client's Place of Employment: _____

Occupation: _____

Highest Education: _____

Marital Status: _____ Length of Marriage: _____

List the members of your Family and all others living in your home: (including spouse):

Name	Age/Birthdates	Relationship	Occupation

DIRECTIONS: Please answer the following questions as fully as possible.

"I am here because of…"

Marital issues □ Health issues □ Job Issues □
Financial Issues □ Parent/child issues □
Issues of the past (guilt, abuse, trauma, neglect, family of origin etc.) □
Other: □ _____

SUPPORT SYSTEM:

Who can you count on for support? *Circle as many as apply:*

Parents Spouse Siblings Employer Church Pastor Therapist Neighbor

Extended Family Close Friends Self-help group Community Services Co-Worker Physician

FAMILY HISTORY

Describe your family of origin (example: did your parents remain married, are they still living, give an age at the time of significant change that occurred.)_____

_____

_____

CHECK THE STATEMENTS THAT BEST DESCRIBE YOUR FAMILY HISTORY

___Warm relationship with father/mother

___Warm relationship with brothers/sisters

___Sibling rivalry

___Father/mother absent physically/emotionally

___Moved frequently

___Parental job/financial instability

___Relatives lived nearby

___Close relationship with grandparents/aunts/uncles/cousins

___Alcohol/drug abuse/other compulsive behavior by father/mother

___Chronic-physical, mental or emotional illness in family members

___Rigid, perfectionist standards

___Frequent/excessive anger and conflict

___Physical/emotional/sexual abuse by family members

In your own words, briefly describe the main problem which prompted you to seek counseling at this

_____

_____

_____

When did these symptoms/problems first appear? _____

What solutions have already been attempted? _____

_____

Have there been times when the problem got better or disappeared? Yes_____ No_____

What do you think helped? _____

_____

Were there times when the problem was especially bad? Yes____ No_____

What made it worse? _____

_____

Are there other people who play a major role in causing your problems? Yes_____ No_____

…. Or in helping you to cope with your problems? Yes_____ No_____

Explain briefly:

_____

_____

_____

_____

RELIGIOUS BACKGROUND

Your religious affiliation: _____

Church you attend: _____

Describe your spiritual beliefs: _____

_____

DEVOPLMENTAL HISTORY

How would you describe your childhood? □ Traumatic □ Painful □ Uneventful □ Great

List any unusual or traumatic events that occurred during your childhood and your age at the time: ___

_____

_____

MEDICAL HISTORY

Date of last examination by physician: _____

Name of Physician: _____ Office Number: _____

Current Medical Conditions: _____

_____

_____

What medications are you currently taking and why: _____

_____

_____

Have you received psychiatric care or counseling of any type before? _____

If yes, please describe: _____

_____

I have attempted suicide in the past. Yes_____ No_____

There is a history of suicide in my extended/nuclear family. Yes_____ No_____

OTHER INFORMATION

Please give us any additional information that you feel is important for us to know:

_____

_____

_____

_____

Who referred you here today? _____

PROBLEM AREAS

In the following list, place a check mark next to each item which identifies a problematic area. Please place two checks by problem areas of greatest concern to you.

____Abuse issues
____Anger
____Bitterness
____Compulsive behavior
____Death of Friend/Family
____Depression
____Eating difficulties/weight change
____Education
____Fearfulness/Anxiety
____Financial Problems
____Legal problems
____Loss of any kind
____Marital problems
____Memory problems
____Physical/Health problems
____Problems with social relationship
____Problems with children
____Problems with parents
____Religious/Spiritual Concerns
____Sleep Patterns
____Self esteem
____Sexual concerns
____Surgery in past 3 years
____Thoughts of hurting others
____Thoughts of suicide
____Trouble making decisions
____Unhappy most of the time
____Use of alcohol
____Use of alcohol by family member
____Use of drugs
____Use of tobacco
____Withdrawal from alcohol and/or drugs
____ Work
____Worry/Anxiety
____Other (specify below)

PLEASE COMPLETE THE FOLLOWING

1. The most important thing to me is….._____
2. I worry about…_____
3. I have sometimes felt guilty about …_____
4. I have been criticized for …._____
5. What makes me angry is…._____
6. My biggest mistakes were…_____
7. What makes me nervous is …._____
8. I often felt that mother…_____
9. I often felt that father …_____
10. Sex to me is…_____
11. God to me is…._____
12. What hurts me most is…_____
13. My biggest problem in life is…_____
14. My temper…_____