NEW CLIENT INFORMATION

Under 18

Name________________________________ (First) (Middle) (Last) Date____________ (Month) (Day) (Year)

Address________________________ City______________ State______ Zip__________

Contact Phone________________ Mobile or Alternate Phone________________

Email________________________

What is your preferred method of having us contact you?
☐ Phone ☐ Email ☐ Texting (number)______________
Is it okay to leave messages for you? ☐ Yes ☐ No

Date of Birth______________ (Month) (Day) (Year) Age______ Gender: ☐ Female ☐ Male Marital Status____________ (If applicable)

What is your preferred name?
(or the preferred name of child if this is being completed by a parent or legal guardian) ________________

Emergency contact phone number________________ Emergency contact person________________

Employment status: ☐ Employed full time ☐ Employed part time ☐ Unemployed ☐ Full time student
☐ Part time student Employer or school ________________

Names and ages of minor children living in the home ________________

If you are a parent/guardian for a minor receiving services, please provide the following information:

Name________________ Contact Phone____________ Email____________

Address________________________ City______________ State______ Zip__________

Relationship: ☐ Parent ☐ Legal guardian ☐ Other__________ Person responsible for payment of services________________

Insurance Information (If applicable)

Name of Insured________________ (If same as above, write "self") Insured's Date of Birth____________ (Month) (Day) (Year)

Insured's Address________________________ Contact Phone________________

Insured's Employer________________ Group ID#__________ Individual ID#__________

Name of Insurance Company________________________ Policy #________________

Insurance Company Claims Address________________________ Phone__________

Agreement for Services

I authorize payment of third party benefits directly to **Solutions Wellness Center** for services rendered for myself and/or my dependents. I further authorize **Solutions Wellness Center** to release all information with respect to myself or my dependents as may be required to process claims for payment for services provided. I understand this may include notifying my employer (or my family member's employer) that I am receiving services if I have EAP benefits. I authorize my insurance company or "provider" to release to **Solutions Wellness Center** any information regarding my claims, or claims of my dependents, for services rendered. I understand that I am ultimately financially responsible to **Solutions Wellness Center** for any monies paid directly to me or my insurance company or any other "payee," and for any other services not covered by my insurance or "payee." I agree to allow **Solutions Wellness Center** to contact me via my preferred method to remind me of appointments.

Client or Authorized Person's Signature________________________ Date____________

PRESENTING CONCERN

How did you get referred to Solutions?____

Please briefly describe your reason for coming in_______________________________________

____

Have you ever had thoughts of wanting to hurt yourself?	☐ Yes	☐ No
Have you ever attempted to hurt yourself?	☐ Yes	☐ No
Are you currently having any thoughts of hurting yourself?	☐ Yes	☐ No
Have you ever had thoughts of seriously hurting someone else?	☐ Yes	☐ No
Have you ever seriously hurt or injured another person?	☐ Yes	☐ No
Are you currently having thoughts of seriously hurting or injuring another person?	☐ Yes	☐ No

Please indicate if you have had any of the following symptoms:

	Never had	Have now	Had in past
Crying spells	☐	☐	☐
Sleeping too much	☐	☐	☐
Difficulty falling/staying asleep	☐	☐	☐
Feeling fatigued	☐	☐	☐
Low energy	☐	☐	☐
Diminished interest or pleasure	☐	☐	☐
Weight loss or weight gain	☐	☐	☐
Depressed mood	☐	☐	☐
Feelings of worthlessness	☐	☐	☐
Difficulty concentrating	☐	☐	☐
Out of control and grandiose moods	☐	☐	☐
Going days without needing to sleep	☐	☐	☐
Racing thoughts	☐	☐	☐
Panic attacks	☐	☐	☐
Excessive stress and/or worry	☐	☐	☐
Irrational fears	☐	☐	☐
Disturbing thoughts you can't get rid of	☐	☐	☐
Compulsive behaviors	☐	☐	☐
Severe emotional of physical trauma	☐	☐	☐
Disturbing memories	☐	☐	☐
Frightening dreams	☐	☐	☐
Trouble staying on task	☐	☐	☐
Hyperactivity	☐	☐	☐
Binge eating	☐	☐	☐
Excessive dieting	☐	☐	☐
Self-induced vomiting	☐	☐	☐
Fears of abandonment	☐	☐	☐
Trouble making decisions on your own	☐	☐	☐
Impulsive behaviors	☐	☐	☐
Difficulty controlling anger	☐	☐	☐
Severe relationship problems	☐	☐	☐

	Never had	Have now	Had in past
Hearing/seeing things that aren't there	☐	☐	☐
Odd or bizarre beliefs	☐	☐	☐
General confusion	☐	☐	☐
Excessive concern with health problems	☐	☐	☐
Problems with sexual performance	☐	☐	☐
Unusual sexual behaviors	☐	☐	☐

What are your best hopes for coming in to Solutions today? ____

____

PREVIOUS TREATMENT

Have you received professional counseling before? ☐ Yes ☐ No

If yes, with whom?________________________________ When?_____________________________

What for? ____

What about your past counseling did you find helpful?______________________________________

____

STRENGTHS AND ABILITIES

What are some of your strengths? ____

What are some of your talents and abilities? ____

PSYCHOSOCIAL HISTORY (To be completed by parent if possible)

Name(s) of parents or primary caregivers: ____

Name of person completing this form: _____________________________________

Mother's relationship to child: ☐ natural parent ☐ step-parent ☐ relative ☐ adoptive parent ☐ other________________________

Mother's Age:_____ Education:______________________ Occupation:______________________

Father's relationship to child: ☐ natural parent ☐ step-parent ☐ relative ☐ adoptive parent ☐ other________________________

Father's Age:_____ Education:______________________ Occupation:______________________

Other parent's relationship to child: ☐ natural parent ☐ step-parent ☐ relative ☐ adoptive parent ☐ other________________________

Other parent's Age:_____ Education:____________________ Occupation:____________________

Relationship history of parents:

Birth parents: Married (got together) when?__________ Separated (if applicable) when? __________

Deceased (☐ mother ☐ father) when?____________

Step-parents: Married (got together) when?____________ Separated (if applicable) when? ____________

Deceased (☐ mother ☐ father) when?_______________

Please provide the following information about child's brothers and sisters:

Name	Age	Gender	Full/step/half	Lives with child?	Parents

Others living in the home and their relationship: ____

Does child share a room with anyone else? ☐ Yes ☐ No If yes, with whom? ________________________

Was child adopted? ☐ Yes ☐ No

If yes, child's age when entered home __________ Does child know? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Was pregnancy with child: wanted? ☐ Yes ☐ No planned? ☐ Yes ☐ No normal? ☐ Yes ☐ No

Was child's mother ill or upset during pregnancy? ☐ Yes ☐ No

If yes, please explain:____

Did mother smoke of use drugs/alcohol during pregnancy? ☐ Yes ☐ No

If yes, please explain:____

Please explain paternal support and acceptance:____

Was child full term? ☐ Yes ☐ No If premature, how early?___________ If overdue, how late?___________

Length of active labor: _________ hours ☐ Easy ☐ Medium ☐ Difficult

Were there any complications in delivery? ☐ Yes ☐ No

If yes, please explain: ____

During the newborn period, did child have problems with:

☐ irritability ☐ difficulty breathing ☐ convulsions/twitching ☐ difficulties with feeding
☐ vomiting ☐ difficulty sleeping ☐ colic ☐ other ___________________

If yes, please explain:____

Did child experience normal weight gain? ☐ Yes ☐ No Was child breast fed? ☐ Yes ☐ No

Please indicate when child was able to do each of the following things:

	Earlier than same sex peers	At about the same time as same sex peers	Later than same sex peers
Sit up	☐	☐	☐
Crawl	☐	☐	☐
Weaned	☐	☐	☐
Walk	☐	☐	☐
Speak single words	☐	☐	☐
Speak sentences	☐	☐	☐
Bowel trained	☐	☐	☐
Bladder trained	☐	☐	☐
Ride a bike	☐	☐	☐
Tell time	☐	☐	☐
Do simple math	☐	☐	☐
Write sentences	☐	☐	☐

Please describe the manner in which toilet training was accomplished: ______________________

Do any members of child's family have a history of: ☐ alcohol or drug abuse? ☐ mental illness? ☐ suicide? ☐ violence?

If so, please elaborate: ______________________

Have any members of child's family had problems with: ☐ learning ☐ ADHD ☐ speech ☐ acting out

If yes, please explain: ______________________

Has child ever experienced something that could be considered traumatic? ☐ Yes ☐ No

If yes, please indicate the type of trauma experienced:

☐ Emotional abuse	☐ Witness to violence	☐ Abandonment
☐ Physical abuse	☐ Victim of violence	☐ Disasters
☐ Sexual abuse	☐ Physical injury	☐ Other:
☐ Neglect	☐ Head injury	______________

If yes, please elaborate: ______________________

EDUCATIONAL HISTORY

What is the child's favorite subject in school?______________ Least favorite?______________

What is the highest grade child has earned on a report card?________ Lowest grade?________

Does or has child participated in extracurricular activities? ☐ Yes ☐ No

If yes, please describe: ______________________

Has child had any specific learning difficulties? ☐ Yes ☐ No

If yes, please explain: ______________________

Has child ever been suspended or expelled from school? ☐ Yes ☐ No

If yes, please explain: ______________________

Please provide the following information about child's educational experience:

Grades	Where did child attend?	Grades earned	List any special education or resources classes	List any behavioral problems	Overall, how was/is child's educational experience during these grades?
K-3rd	☐public school ☐private school ☐home schooled ☐did not attend	☐above average ☐average ☐below average ☐failing	__________ __________ __________ __________ (☐does not apply)	__________ __________ __________ __________ (☐does not apply)	☐very positive ☐positive ☐uneventful ☐negative ☐very negative
4th-6th	☐public school ☐private school ☐home schooled ☐did not attend	☐above average ☐average ☐below average ☐failing	__________ __________ __________ __________ (☐does not apply)	__________ __________ __________ __________ (☐does not apply)	☐very positive ☐positive ☐uneventful ☐negative ☐very negative
7th-9th	☐public school ☐private school ☐home schooled ☐did not attend	☐above average ☐average ☐below average ☐failing	__________ __________ __________ __________ (☐does not apply)	__________ __________ __________ __________ (☐does not apply)	☐very positive ☐positive ☐uneventful ☐negative ☐very negative
10th-12th	☐public school ☐private school ☐home schooled ☐did not attend	☐above average ☐average ☐below average ☐failing	__________ __________ __________ __________ (☐does not apply)	__________ __________ __________ __________ (☐does not apply)	☐very positive ☐positive ☐uneventful ☐negative ☐very negative

SOCIAL

Child's relationship to siblings and peers can be described as: (check all that apply)

☐ individual play ☐ group play ☐ competitive ☐ cooperative ☐ leadership role ☐ a follower

Does child have a best friend? ☐ Yes ☐ No If yes, what is the best friend's name?____________________

Please describe how child responds in strange or new situations:______________________________

Please mark on the line where you believe child to be on the following dimensions:

Withdrawn -- **Outgoing**

Uncooperative -- **Cooperative**

Distant -- **Friendly**

Quiet -- **Talkative**

Aggressive -- **Peaceful**

Disrespectful -- **Respectful**

LEGAL HISTORY

Has child ever had difficulty with the police? ☐ Yes ☐ No

If yes, please explain:____

Has child ever appeared in juvenile court? ☐ Yes ☐ No

If yes, please explain:____

Has child ever been on probation? ☐ Yes ☐ No If yes, please explain:

From (date)	To (date)	Reason	Probation officer

STRENGTHS

Please describe child's strengths, special interests, hobbies, skills, etc. ______________________

____

MEDICAL STATUS

Do you have a primary care physician? ☐ Yes ☐ No

If yes, please provide name and contact information: ______________________

____

Do you have any current medical problems? ☐ Yes ☐ No

If yes, please describe ____

Do you have any chronic medical problems? ☐ Yes ☐ No

If yes, please describe ____

Do you currently take any medications? ☐ Yes ☐ No

If yes, please list them, their doses and what you take them for:

Medication	Dose	Purpose

Are you sexually active? ☐ Yes ☐ No

Do you have any issues with risky sexual behaviors or sexual performance? ☐ Yes ☐ No

If yes, please explain ____

(If female) Are you currently pregnant? ☐ Yes ☐ No

If yes, how far along are you?___________ When is your due date?____________________

How many total pregnancies have you had? ___________ How many live births? _______________

Please indicate if you have had any of the following symptoms:

	Never had	Have now	Had in past
Frequent or severe headaches	☐	☐	☐
High fevers	☐	☐	☐
Dizziness or fainting spells	☐	☐	☐
Eye problems/glaucoma	☐	☐	☐
Vision problems	☐	☐	☐
Sinus problems	☐	☐	☐
Hearing problems/earaches	☐	☐	☐
Head injury	☐	☐	☐
Seizures/convulsions	☐	☐	☐
Thyroid trouble	☐	☐	☐
Chronic fatigue	☐	☐	☐
Asthma/shortness of breath	☐	☐	☐
Chronic cough/lung disease	☐	☐	☐
Palpitation or pounding heart	☐	☐	☐
Heart attack/heart trouble	☐	☐	☐
High blood pressure	☐	☐	☐
Kidney disease	☐	☐	☐
Stroke	☐	☐	☐
Jaundice/liver disorder	☐	☐	☐
Stomach problems	☐	☐	☐
Arthritis/gout	☐	☐	☐
Encephalitis	☐	☐	☐
Meningitis	☐	☐	☐
Tumors	☐	☐	☐
Diabetes	☐	☐	☐
Anemia	☐	☐	☐
Frequent/painful urination	☐	☐	☐
Other illness (please explain)	☐	☐	☐

____

DRUGS AND ALCOHOL

Do you have a history of substance use? ☐ Yes ☐ No

Please indicate your history of drug or alcohol use:

Check if never used	Substance	Age first used	Last use	Over the last year how often have you used it?	Over the last year what is the normal amount you use in a 24 hr. period of time?	What is the most you have ever used in a 24 hr. period of time?	How have you used it?
☐	CAFFEINE Coffee, Energy drinks						
☐	NICOTINE Cigarettes, Cigars, Chew, Vape Pens						
☐	ALCOHOL Beer, Wine						
☐	ALCOHOL Hard liquor						
☐	CANNABIS THC, Marijuana, Hash						

Check if never used	Substance	Age first used	Last use	Over the last year how often have you used it?	Over the last year what is the normal amount you use in a 24 hr. period of time?	What is the most you have ever used in a 24 hr. period of time?	How have you used it?
☐	HALLUCINOGENS LSD, Acid, Mushrooms, Peyote						
☐	COCAINE Crack, Blow, Coke						
☐	METHAMPHETAMINE Meth, Crank, Ice, Speed						
☐	PRESCRIPTION PAIN MEDS Oxys, Methadone, Vicodin						
☐	HEROIN Opium						
☐	BENZODIAZEPINES Valium, Xanax, Klonopin						
☐	BARBITURATES Phenobarbital						
☐	DESIGNER DRUGS XTC, Ketamine, PCP, GHB						
☐	STEROIDS Stackers, Juice, HGH						
☐	INHALANTS Paint, Glue, Gas						
☐	OTHER -------------------------------------						

Have you ever experienced blackouts or lost periods of time? ☐ Yes ☐ No

Have you noticed that it takes more drugs or alcohol to get you drunk or high than it used to? ☐ Yes ☐ No

Have you had any drug or alcohol related medical problems? ☐ Yes ☐ No

Has your use of drugs or alcohol affected your home life or relationships? ☐ Yes ☐ No

Has your use of alcohol or drugs caused you to be late, miss work (or school) or to lose a job? ☐ Yes ☐ No

Have you ever used more drugs or alcohol than you intended to? ☐ Yes ☐ No

Have you engaged in illegal activities to obtain drugs or alcohol? ☐ Yes ☐ No

Please check all of the symptoms you have experienced following a period of heavy drug or alcohol use:

- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ Shakiness/tremors
- ☐ Fever/sweating
- ☐ Increased heart rate
- ☐ Increased blood pressure
- ☐ Feeling restless
- ☐ Concentration difficulties
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of appetite
- ☐ Increased appetite
- ☐ Irritability
- ☐ Seizures
- ☐ Depression
- ☐ Hallucinations
- ☐ Cold chills
- ☐ Memory problems
- ☐ Runny nose/eyes
- ☐ Anxiety
- ☐ Confusion
- ☐ Fatigue
- ☐ Low energy
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Headaches
- ☐ Achy body
- ☐ None of these

Is there a particular spiritual belief with which you identify? ☐ Yes ☐ No

If yes, please elaborate ______________________________

What about your culture is important for us to know?______________________________

____

______________________________ Signature

______________________________ Date