NEW CLIENT INFORMATION

Age 18 and Up

Name_____ Date_____
(First) (Middle) (Last) (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_____ Age_____ Gender: ☐ Female ☐ Male Marital Status_____
(Month) (Day) (Year) (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_____ Insured's Date of Birth_____
(If same as above, write "self") (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

Where were you born?_____

What are the names of your biological parents? _____

Please list your brothers and sisters starting with the oldest:

Name	How much older/younger are they than you?	How would you describe your relationship with him/her?

What were your parents' occupations at the time of your birth? _____

What was their relationship like at the time of your birth?_____

Were you raised by both parents? □ Yes □ No If not, how old were you when they separated? _____

Who raised you primarily?_____

Did you have a step-parent(s)? □ Yes □ No Step parents' name(s) _____

Please describe how you were disciplined as a child: _____

How would you describe your personality as a child? _____

What kinds of activities did you enjoy doing as a child? _____

Please list the different places you lived from the time you were born until you left home:

Place	From what age to what age?

How would you describe your personality as a teenager? _____

What kinds of things did you enjoy doing as a teenager? _____

How would you describe your relationship with your parents/caregivers during your teenage years?

_____

How old were you when you left home?_____ Where did you go? _____

Please give the following information for people with whom you have been seriously involved (include marriages, live in relationships, common-law marriages, etc.)

Partner's name	Your age when you got together	Your age when you separated (If applicable)	How would you describe your relationship with this person?	Why did you separate? (If applicable)

Regarding your current relationship with your spouse or significant other (if applicable) what are some things that seem to be going well? _____

What kinds of things do you struggle with? _____

Please provide the following information about your biological children (if applicable):

Child's name	Age	Name of other parent

Please list any other children who are currently living with you (if applicable):

Child's name	Age	Names of biological parents

Regarding the parenting of children in your care, what are some things that seem to be going well?

_____

What are some things with which you might be struggling? _____

Do any members of your family have a history of: □ alcohol or drug abuse? □ mental illness? □ suicide? □ violence?

If so, please elaborate: _____

Have you ever experienced something that could be considered traumatic? □ Yes □ No

If yes, please indicate the type of trauma you experienced:

□ Emotional abuse □ Witness to violence □ Combat
□ Physical abuse □ Victim of violence □ Disasters
□ Sexual abuse □ Physical injury □ Other:
□ Neglect □ Head injury _____

If yes, please elaborate: _____

How many years of education do you have? _____

Did you have any difficulties learning in school? □ Yes □ No

If yes, please explain: _____

Did you serve in the military? □ Yes □ No

If yes, from _____ to _____ Branch:_____

Discharge status:_____ Rank at discharge:_____

What is your usual or last occupation? _____

Please describe how you feel about you current employment situation (if applicable).

_____

Please provide the following information regarding significant jobs you have had since high school.

Job title	Place of employment	Dates of employment	Overall, how would you describe this job experience?	Reason for leaving (if applicable)

Have you had any significant legal involvement? □ Yes □ No

If yes, please provide the following information:

Charges	Date(s) of occurrence	Did the charge(s) lead to conviction?	Outcome (probation, jail, fines, etc.)	Were alcohol or drugs involved?

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	☐	☐	☐
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	□ Concentration difficulties	□ Depression	□ Fatigue
□ Sleeping too much	□ Weight loss	□ Hallucinations	□ Low energy
□ Shakiness/tremors	□ Weight gain	□ Cold chills	□ Nausea/vomiting
□ Fever/sweating	□ Loss of appetite	□ Memory problems	□ Diarrhea
□ Increased heart rate	□ Increased appetite	□ Runny nose/eyes	□ Headaches
□ Increased blood pressure	□ Irritability	□ Anxiety	□ Achy body
□ Feeling restless	□ Seizures	□ Confusion	□ 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