



# 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 \_\_\_\_\_

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling/staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling fatigued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished interest or pleasure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss or weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of control and grandiose moods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going days without needing to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive stress and/or worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irrational fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbing thoughts you can't get rid of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe emotional or physical trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disturbing memories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frightening dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble staying on task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-induced vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fears of abandonment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble making decisions on your own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty controlling anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems/glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems/earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack/heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice/liver disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent/painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other illness (please explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\_\_\_\_\_

**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?
<input type="checkbox"/>	CAFFEINE Coffee, Energy drinks						
<input type="checkbox"/>	NICOTINE Cigarettes, Cigars, Chew, Vape Pens						
<input type="checkbox"/>	ALCOHOL Beer, Wine						
<input type="checkbox"/>	ALCOHOL Hard liquor						
<input type="checkbox"/>	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?
<input type="checkbox"/>	HALLUCINOGENS LSD, Acid, Mushrooms, Peyote						
<input type="checkbox"/>	COCAINE Crack, Blow, Coke						
<input type="checkbox"/>	METHAMPHETAMINE Meth, Crank, Ice, Speed						
<input type="checkbox"/>	PRESCRIPTION PAIN MEDS Oxys, Methadone, Vicodin						
<input type="checkbox"/>	HEROIN Opium						
<input type="checkbox"/>	BENZODIAZEPINES Valium, Xanax, Klonopin						
<input type="checkbox"/>	BARBITURATES Phenobarbital						
<input type="checkbox"/>	DESIGNER DRUGS XTC, Ketamine, PCP, GHB						
<input type="checkbox"/>	STEROIDS Stackers, Juice, HGH						
<input type="checkbox"/>	INHALANTS Paint, Glue, Gas						
<input type="checkbox"/>	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:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Difficulty sleeping      | <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Depression      | <input type="checkbox"/> Fatigue         |
| <input type="checkbox"/> Sleeping too much        | <input type="checkbox"/> Weight loss                | <input type="checkbox"/> Hallucinations  | <input type="checkbox"/> Low energy      |
| <input type="checkbox"/> Shakiness/tremors        | <input type="checkbox"/> Weight gain                | <input type="checkbox"/> Cold chills     | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Fever/sweating           | <input type="checkbox"/> Loss of appetite           | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Increased heart rate     | <input type="checkbox"/> Increased appetite         | <input type="checkbox"/> Runny nose/eyes | <input type="checkbox"/> Headaches       |
| <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Irritability               | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Achy body       |
| <input type="checkbox"/> Feeling restless         | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Confusion       | <input type="checkbox"/> 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 \_\_\_\_\_