

New Client Information

Today's Date: _____	Date of Birth: _____ Age: _____
Name: _____	SS#: _____ <input type="checkbox"/> Male, <input type="checkbox"/> Female, <input type="checkbox"/> _____
Address: _____	Education/Degree: _____
_____	Occupation: _____
City/State/Zip: _____	Employer: _____
Phones: (✓ = best place to leave a message)	<input type="checkbox"/> Single, <input type="checkbox"/> Married, <input type="checkbox"/> Partnered, <input type="checkbox"/> Separated,
<input type="checkbox"/> Home: _____	<input type="checkbox"/> Divorced, <input type="checkbox"/> Widowed, <input type="checkbox"/> Other: _____
<input type="checkbox"/> Work: _____	Person Responsible for Payment: <input type="checkbox"/> Self, <input type="checkbox"/> Other:
<input type="checkbox"/> Cell/Other: _____	Name: _____
E-Mail: _____	Address: _____
URL: _____	Phones: _____
Referred by: _____	<input type="checkbox"/> Bill Insurance: Carrier: _____ ID No.: _____
	(Please provide insurance card & picture ID)

What brings you here at this time?

How long has this been going on?

What would you like to address?

What outcome would you like to have happen as a result of being here?

List members in your current household/family (i.e. names, ages, relationship):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List family of origin (i.e. name, age, relationship, location):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Therapy (with whom, when, for how long):

_____	_____	_____
_____	_____	_____