Sullivan Counseling Inc.

New client information

GENERAL INFORMATION:

The information you provide here is protected as confidential information.

Today's date: _____

Name: _____

Date of Birth: _____ Gender: □ M / □ F

Address: _____

Home Phone:_____ May I leave a message? □ Yes □ No

Cell/Other Phone:_____ May I leave a message? □ Yes □ No

E-mail:_____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

How were you referred? _____

Are you currently employed? □ Yes/□ No

If yes, what kind of work do you do?

_____

Who Lives in your home?

Name:	Relationship to you:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list if you have any children & age (if not listed above):

_____

What brings you here today?

_____
_____
_____

What would you like to accomplish during your time in therapy?

_____
_____
_____

Have you experienced significant life changes or stressful events recently?

_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

HEALTH & MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

2. How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

3. How would you rate your current appetite or eating patterns?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

4. Are you currently experiencing overwhelming sadness, grief or depression?

□ No □ Yes

If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No □ Yes

If yes, when did you begin experiencing this? _____

6. Are you currently experiencing chronic pain? □ No □ Yes

If yes, please describe _____

7. Do you drink alcohol? □ No □ Yes

If yes, how often_____

MENTAL HEALTH HISTORY:

	Self:	Family Member:
Alcohol/Substance Abuse	□ yes/□ no	□ yes/□ no
Anxiety	□ yes/□ no	□ yes/□ no
Depression	□ yes/□ no	□ yes/□ no
Domestic Violence	□ yes/□ no	□ yes/□ no
Eating Disorders	□ yes/□ no	□ yes/□ no
Obesity	□ yes/□ no	□ yes/□ no
Obsessive Compulsive Behavior	□ yes/□ no	□ yes/□ no
Schizophrenia	□ yes/□ no	□ yes/□ no
Suicide Attempts	□ yes/□ no	□ yes/□ no
Bipolar Disorder	□ yes/□ no	□ yes/□ no
Attention Deficit Disorder	□ yes/□ no	□ yes/□ no

Have you previously received any type of mental health services?

□ No □ Yes

If yes, please list previous therapist/practitioner/psychiatrist:

_____

_____

What was the outcome? _____

Have you ever been prescribed psychiatric medication?

□ No □ Yes