



NEW CLIENT INFORMATION FORM

Please provide the following information and answer the questions below.

Client Information

Date: _____

Name: _____

Home Phone: _____ Cell Phone: _____

Best time to call? _____

Is it okay to leave messages at these numbers? Yes No

If no, please list which number it is okay to leave a message _____

E-Mail Address: _____

Address: _____

Street Address

City

State

Zip

How long have you been living at this address? _____

Occupation: _____

Date of Birth: _____

For appointment scheduling, what are the best:

Times of day: _____

Days of the week: _____

Marital Status:

Never Married Married Domestic Partnership Divorced Widowed

Emergency Contact Information:

Name: _____

Relationship: _____

Phone: _____

Please list the names and relationships of the five most important people in your life:

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have pets? Yes No

If yes, please list: _____

Education: _____

How would you rate your overall physical health?

Excellent Great Good Fair Poor

Do you have any sleep problems? Yes No

If yes, please describe: _____

Are you dealing with any past or current addictions? Yes No

If yes, please describe: _____

Have you had any issues with Depression, Anxiety, or ADD/ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)? Yes No

If yes, please describe: _____

Are you currently seeing a therapist? Yes No

If yes, please describe what issues your addressing in therapy:

Are you currently taking any medications? Yes No

If yes, please list:

Are you usually: Early On Time Running Late

Do you exercise regularly? Yes No

If yes, please describe what you do and how often:

How often do you watch television?

What are your favorite hobbies and sports?

What do you do for fun?

What is your spiritual orientation?

When you treat yourself, what are things you like to do?

What is your idea of a perfect vacation?

How did you hear about me?
