Peace Counseling & Consulting, LLC

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New Client Information Sheet

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: __/__/__ Ethnicity: _____ Sex: _____ Pronoun Preferences:_____
Marital Status: ___ Never Married ___ Domestic Partnership ___ Married ___ Separated ___ Divorced
___ Widowed ___ Other: _____

Cell: _____ Okay to leave a message? __Yes __No / Okay to text? __Yes __ No
Home: _____ Okay to leave a message? ___Yes ___ No
Work: _____ Okay to leave a message? ___ Yes ___ No

Email: _____ Preferred method of contact: _____
*Please note: Email correspondence is not considered to be a confidential form of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
__ No __Yes, please list previous treatment type, dates, & name of therapist or practitioner:_____
_____

Have you ever been diagnosed with a mental health disorder?
__ No __Yes, please list (include date of diagnosis and name of provider): _____
_____

Have you ever been prescribed psychiatric medication?
__No __Yes, please list and provide dates: _____
_____

Reason for currently seeking therapy:_____
_____
_____

Have there been any recent family changes (new baby, death, breakup, etc.) which may be related to your current reason for seeking therapy? __ No __ Yes, please explain: _____

GENERAL HEALTH & MENTAL HEALTH INFORMAION

1) How would you rate your current physical health? (place a check or 'X' on scale below)

   (Poor) ___1 ___2 ___3 ___4 ___5 ___6 ___7 ___8 ___9 ___10 (Excellent)

   Any current health issues you are experiencing? _____
   _____

2) Average hours of sleep a night? _____
   Any recent sleep issues (more/less)? _____

3) How many times per week do you exercise? _____
   Types of exercise you enjoy? _____

4) Any difficulties you experience with appetite or eating patterns? _____
   Any recent changes in eating (more/less)? _____

5) Are you currently experiencing:
   -Overwhelming sadness, grief, or depression? __ No __ Yes
   -Anxiety, panic attacks, or phobias? __ No __ Yes
   -Chronic pain? __ No __ Yes
   -Thoughts about suicide? __ No __ Yes

6) Do you regularly consume alcohol? _____ If yes, how many drinks per week? _____

7) Do you engage in recreational drug use? _____ If yes, please describe use: _____
_____

8) Are you currently in a romantic relationship? _____
If yes, for how long? _____
On a scale of 1-10, how would you rate your satisfaction with your relationship? _____
Have you ever experienced physical abuse or violence in a relationship? _____
Is there any type of abuse occurring in your current relationship? _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, maternal uncle, etc.):

Alcohol/Substance Abuse	__ No __Yes, who: _____
Anxiety	__ No __Yes, who: _____
Depression	__ No __Yes, who: _____
Domestic Violence	__ No __Yes, who: _____
Eating Disorders	__ No __Yes, who: _____
Bipolar Disorder	__ No __Yes, who: _____
Obsessive Compulsive Behavior	__ No __Yes, who: _____
Schizophrenia	__ No __Yes, who: _____
Suicide	__ No __Yes, who: _____

ADDITIONAL INFORMATION

1) Are you currently employed? __ No __ Yes, where? _____
Do you enjoy your work? Is there anything stressful or unsatisfactory about your current job? _____
_____

2) Are you currently a student? __ No __ Yes, where? _____
Are you satisfied with school? If not, why? _____
_____

3) Do you consider yourself to be spiritual or religious? ___No ___ Yes, please describe: _____
_____

4) What would you like to accomplish out of your time in therapy? _____
_____
_____

IN CASE OF EMERGENCY:

Name of emergency contact: _____ Relationship to you: _____
Phone: _____

Anything else you want me to know about you? _____
_____
_____

Thank you and I look forward to working with you!