New Client Form

Personal and Family Record

To make our first meeting more productive, please give accurate and complete responses to every section of this form.

Date_____
Client Name_____ Age_____ Birthdate_____
Address_____ City_____ State_____Zip_____
Phone (home)_____ Work_____ Cell_____
Employer_____ How Long_____ Position_____
Previous types of work_____ Social Security Number_____-_____-_____

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4
Other_____

Marital Status:
Single, never married_____ Engaged_____ Living together without marriage_____
Separated____ How long____ Divorced____ How Long____ Widow/er____ How long_____
Married____ Spouse name_____ Age____ Occupation_____
How long married to this spouse_____ Total number of prior marriages for you_____
For your spouse_____

Children	Age	Sex	Relationship to You	Living in your Home

Counseling History

Have you ever attempted suicide or homicide in the past? Yes____ No____ If yes, how?
_____
Is there a history of suicide in your nuclear and/or extended family? Yes____ No____
Have you ever inflicted burns or wounds to yourself? Yes____ No____
Are you presently suicidal or homicidal? Yes____ No____

What event(s) in the recent past has/have prompted you to seek counseling? _____
_____

What do you hope to gain from counseling? _____
_____
What is your religious preference? _____ Church_____
How strong is the influence of your church in your life?_____
Pastor_____

Medical Information

Family Physician_____

Are you currently on medication? Yes____ No____

Name of medication	Dosage and Frequency	Prescribing Physician

Has it been more than a year since your last physical exam including blood tests? Yes___ No___

If so, how long?_____

List any previous health problems, operative procedures and medical hospitalizations:

Problem	Dates	Treatment

Please list any previous counseling experiences.

Place(s)_____

Length of time there _____ Dates_____

Have you ever been admitted to the hospital for mental health or addiction issues?

Place(s) _____

Length of time there _____ Dates_____

Name of current doctor and/or therapist _____

List all medications you have taken **in the past** for anxiety, depression and/or sleep.

_____

Substance Abuse History:

Describe your current usage, or usage within the past year (inclusive of alcohol, caffeine and tobacco).

Substance	**Amount**	**Frequency**	**Age of 1st Use**	**Age Regular Use**	**Last Use**

Have you experienced a recent increase in the usage of alcohol and/or other substances?

Yes____ No____

Do you see your current usage as a problem? Yes____ No____ If yes, when did it become problematic? _____

Please describe any previous experience with drugs or alcohol. _____

_____

Circle any recent losses you have experienced.

Family Health Disruption of Lifestyle Job Significant Other

Other_____

List your strengths and weaknesses.

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____

Developmental History

List members of the family of origin and how you got along with each one.

Family Member Comment

_____

_____

_____

_____

_____

_____

What your birth order?_____of_____children. Who primarily raised you? _____

How would you describe your childhood? Traumatic_____ Painful_____ Uneventful___

Were there any unusual or traumatic experiences for you as a child?

Date Age Event

_____

_____

_____

Circle any PROBLEMS that concern you now:

Relationship(s) with: Spouse Children Parent In-Laws Co-workers Friends

Alcohol Street Drugs Prescription Drugs Binge eating Excessive dieting or exercise

Shopping Work too much Procrastination Communication Depression Anger

Grief Gender identity Sex Career Loneliness Mood Swings Self-esteem

Codependency Stress Fear Anxiety Feelings about church or God

Is there anything else that you feel would be beneficial for the counselor to know?

_____

_____

_____

_____

_____

In signing below, I affirm that the information given on this form is true and complete.

Signature_____ Date_____ For minor: _____

Consent for release of verbal/written information

Patient Name_____ Date of Birth_____
Address_____ SS#_____-_____-_____
I, the undersigned patient or legal guardian, hereby authorize___verbal and/or___written information to be released by:

_____ (_____)_____-_____
Name of Releasing Person Phone Number

_____
Street Address or P.O. Box City State Zip

RELEASE TO:

Family/Significant Other Name:_____Phone:_____
Address:_____

Facility Representative Name:_____Phone:_____
Address:_____

Clergy Name:_____Phone:_____
Address:_____

Therapist/M.D./Other Name:_____Phone:_____
Address:_____

Purpose Diagnostic and treatment planning; facilitating and coordinating continuing treatment; discharge and aftercare planning and support; or, for the specified purpose of:_____

Information to be released: _____

A photostatic copy of this authorization shall be considered as effective and valid as the original. At anytime, I may make written request to withdraw this release of information. Such withdrawal must be presented to the therapist to whom this consent was orinally given.

_____ _____ _____-_____-_____
Signature of Client or Guardian Date Signed Social Security Number

Name of minor client or adult client under guardianship is _____

If Guardian, legal authority is as: Parent____ Custodial parent____ Trustee____ Court appointed guardian____. If other, specify_____

Thank you for choosing this office for your counseling needs. We are committed to giving you the highest quality of care. To assist you in understanding the policies of this office, we are providing the following information.

Appointments: If an appointment must be cancelled, a minimum of 24 hours notice is required; otherwise, you are subject to being charged full fee for the appointment. To cancel or reschedule an appointment, please call 214.402.6634 and leave a message. If a client misses two appointments without notification of cancellation the therapist may no longer treat them.

Emergencies: In case of an emergency call 214.402.6634. If Mr. Saenz is in session leave a message on his voicemail, and he will return the call as soon as possible. If the situation is such that it cannot wait for his return, dial 911.

Financial Responsibility: We require payment at the time of services rendered. Cash, check or money order payable to Robert Saenz are acceptable forms of payment.

Please sign below to indicate that you have read and understand the above procedures and are consenting to receive treatment under these terms.

_____ _____

Patient/Guardian Signature Date