New Hope Personal Growth Center

Client Identification Information **Date ______/______/______**

Referred by:					
Client Information					
Name (Last) (First) (MI)		Age	Birthdate (mm/dd/yyyy) ______/______/________	Sex M ☐ F ☐	
Address (City) (State) (Zip)					
Social Security Number ___________-_______-______________		Home Phone ( )	Cell Phone ( )		
Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ (Please indicate # of times)					
Religious Affiliation:	Name of Church:				
Employment: Full time ☐ Part time ☐ Student ☐ Disability ☐ Retired ☐ Military Service ☐					
Education (highest grade completed)	Veteran Yes ☐ No ☐ [date(s) of service]				
Employer	Your Work Phone				
Occupation	How Long Employed?				

State briefly reason for coming in…

Continue to next page –

If client is a minor or dependent adult, also complete supplement 1 for each parent/responsible adult – see page 5

Family History				
Family Members	**Age**	**History of Mental Health Issues? Explain**	**Living? (Yes/No)**	**Occupation**
Spouse's Name				
Mother's Name				
Father's Name				
Stepmother's Name				
Stepfather's Name				
Other significant person responsible for raising you				
Other significant person responsible for raising you				

Names, ages and gender for children of person completing form as well as any other people living in client's household

Name	Relationship to Client	Gender: M/F	Age

Are there any deceased children?

Number of brothers and sisters (living? deceased?)

Other persons living in current household and their relationship

Continue to next page –

Client Health Information	
Physician's name	Date of last physical exam
Do you have any current physical health concerns/problems? Please describe.	Are your health problems being treated?
Surgical History (type of surgery & your age at the time of surgery)	Date of Surgery
Please list current medications (including vitamins & herbs)	Dosage

Previous psychiatric or chemical dependency hospitalization? Yes ☐ No ☐
If yes, where? When?

Please briefly explain reason for hospitalization.

Continue to next page –

Have you ever seen any of the following for help with a problem?		
Specialist	Reason for services	Dates of service
Psychiatrist		
Psychologist		
Mental Health Counselor		
Social Worker		
Minister		
Chemical Dependency Counselor		
DHS Social Worker		
Probation Officer or Juvenile Court Officer		
Other		

Substance Use History

___ Denies Substance abuse history

Substance Name	Age Started	Current Amount	Frequency of Use	Last Used
Alcohol				
Marijuana				
Methamphetamine				
Over-the-counter drug abuse				
Prescription drug abuse				
other				
other				

Continue to next page –

Suppliment 1 – parent/responsible adult information

Parent/Responsible-Adult Name (Last) (First) (MI)	Relationship to Client?
Address (City) (State) (Zip)	

Social Security Number ___________-_______-______________	Home Phone ( )	Cell Phone ( )
Birthdate (mm/dd/yyyy) ______/______/_______	Sex M ___ F ___	

Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Partnered ___
(Indicate # of times)

Employment: Full time ___ Part time ___ Student ___ Disability ___ Retired ___ Military Serv. ___

Education (highest grade completed)	Veteran Yes ___ No ___ [date(s) of service]
Employer	Your Work Phone
Occupation	How Long Employed?

Please list all other people living in household, relationship to client, gender and age

Name	Relationship to Client	Gender: M/F	Age