

New Hope Personal Growth Center
Dependent Client Identification Information

Date ____/____/____

Referred by:					
Dependent Client Information					
Name (Last)	(First)	(MI)	Age	Birthdate (mm/dd/yyyy)	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Address		(City)	(State)	(Zip)	
Social Security Number ____-____-____			Home Phone ()	Cell Phone ()	
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> (#) Divorced <input type="checkbox"/> (#) Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/>					
Religious Affiliation:			Name of Church:		
Employment: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Disability <input type="checkbox"/> Retired <input type="checkbox"/> Military Service <input type="checkbox"/>					
Education (highest grade completed)			Veteran Yes <input type="checkbox"/> No <input type="checkbox"/> Date(s) of Service:		
Employer			Your Work Phone		
Occupation			How Long Employed?		
Client's parent/responsible adult information (please complete for each household)					
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 <input type="checkbox"/> F <input type="checkbox"/>		
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> (#) Divorced <input type="checkbox"/> (#) Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/>					
Employment: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Disability <input type="checkbox"/> Retired <input type="checkbox"/> Military Service <input type="checkbox"/>					
Education (highest grade completed)			Veteran Yes <input type="checkbox"/> No <input type="checkbox"/> (time of service)		
Employer			Your Work Phone		
Occupation			How Long Employed?		

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Please list all other people living in household (described on the previous page) including the relationship to

client, gender and age of each person. (Please list any deceased family members.)

Name	Relationship to Client	Gender: M/F	Age

Client's additional parent/responsible adult information - continued

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 <input type="checkbox"/>	F <input type="checkbox"/>
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> (#) Divorced <input type="checkbox"/> (#) Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/>			
Employment: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Disability <input type="checkbox"/> Retired <input type="checkbox"/> Military Service <input type="checkbox"/>			
Education (highest grade completed)	Veteran Yes <input type="checkbox"/> No <input type="checkbox"/> (time of service)		
Employer	Your Work Phone		
Occupation	How Long Employed?		

Please list all other people living in this household, including the relationship to client, gender and age of each person. (Please list any deceased family members.)

Name	Relationship to Client	Gender: M/F	Age

Describe how often the client spends time in each home. (ie. visitation schedule, alternating custody, etc.)

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Family History

Family Members (complete all those that apply)	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 client				

Client Health Information

Physician's name	Date of last physical exam
Does the client have any current physical health concerns/problems? Please describe.	Are the health problems being treated?
Surgical History – type of surgery	Date of surgery
Please list current medications (including vitamins & herbs)	Dosage

Has the client been previously hospitalized for psychiatric care or chemical dependency? Yes No
 If yes, where? When?

Please explain reason for hospitalization.

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Has the client ever seen any of the following for help with a problem?

Specialist	Reason for services	Dates of service
<input type="checkbox"/> Psychiatrist		
<input type="checkbox"/> Psychologist		
<input type="checkbox"/> Mental Health Counselor		
<input type="checkbox"/> Social Worker		
<input type="checkbox"/> Minister		
<input type="checkbox"/> Chemical Dependency Counselor		
<input type="checkbox"/> DHS Social Worker		
<input type="checkbox"/> Probation Officer or Juvenile Court Officer		
<input type="checkbox"/> Other		

Client's Substance Use History

The client does not use any substances.

Substance Name	Age Started	Current Amount	Frequency of Use	Last Used
<input type="checkbox"/> Alcohol				
<input type="checkbox"/> Marijuana				
<input type="checkbox"/> Methamphetamine				
<input type="checkbox"/> Over-the-counter drug abuse				
<input type="checkbox"/> Prescription drug abuse				
<input type="checkbox"/> Tobacco products				
<input type="checkbox"/> other				
<input type="checkbox"/> other				