New Hope Counseling, Coaching & Consulting, PC

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

Referred by:			
Client Information (***If client is a minor or dependent adult***, also complete supplement 1 for each parent/responsible adult – see page 5)			
Name (Last) (First) (MI)	Age	Birthdate (mm/dd/yyyy) ______/______/_______	Sex M F
Address (City) (State) (Zip)			
Social Security Number: ____________-________-________________ Email Address (if used regularly): ____________________________________	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?		

Insurance Card Holder Information			
Name (Last) (First) (MI)	Age	Birthdate (mm/dd/yyyy) ______/______/_______	Sex M F
Address (City) (State) (Zip)			
Social Security Number ____________-________-________________	Home Phone ( )	Cell Phone ( )	
Employer	Your Work Phone		
Occupation	How Long Employed?		

State briefly reason for coming in…

Continue to next page –

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 to you:

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				

Supplement 1 – parent/responsible adult information (*If client is a minor or dependent adult*)			
Parent/Responsible-Adult Name (Last) (First) (MI)			Relationship to Client?
Address (City) (State) (Zip)			
Social Security Number: ___________-_______-______________ Email Address (if used regularly): _________________________________	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