INSIGHTS COLLABORATIVE THERAPY GROUP

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NEW CLIENT INFORMATION

(adult)

Welcome to Insights. We realize that seeking help from a mental health professional is often a difficult decision. We recognize and applaud your courage and willingness.

The purpose of this form is to obtain information about you so Insights can craft your therapy to be as effective and efficient as possible. Some questions are personal and may be sensitive or even uncomfortable for you. They are asked in an effort to quickly begin building a complete picture of who you are, which in turn will save valuable therapy time. All client records are strictly confidential and will not be seen by anyone without your written permission unless required by law. If you have any questions, please discuss them with your therapist.

CONTACT INFORMATION

Today's date: _____

Name: _____ Occupation: _____

Home Address: _____ Employer: _____

City: _____ State: _____ Zip: _____ Employed: Full Time_____ Part Time_____

Home Phone:_____ Student: Full Time _____ Part Time_____

Email Address: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Work Phone: _____

Person financially responsible for this account: _____

Contact Permissions:

May we contact you at home?	□yes □no	May we leave a message at home?	□yes □no
May we contact you at work?	□yes □no	May we leave a message at work?	□yes □no
May we contact you by cell phone?	□yes □no	May we leave a message on your cell phone?	□yes □no
May we contact you by email?	□yes □no		

Please keep in mind that communications via email over the Internet are not secure. Although unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____

Cell Phone: _____ Permission to Contact in Emergency □yes □no

SPOUSE CONTACT INFORMATION

Name: _____ Home Phone: _____

Home Address: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Occupation: _____ Employer:_____

SOCIAL INFORMATION

Children:

Name	Type (biological, step, etc.)	Age	Living at home? (yes/no)	Drug/Alcohol Problems? (yes/no)	Mental/Emotional Problems? (yes/no)

Family of Origin (Mother, Father, Siblings, etc.):

Name	Relationship	Age	Deceased?	Drug/Alcohol Problems? (yes/no)	Mental/Emotional Problems? (yes/no)
	mother				
	father				

Relationship status:

□single (never married) □married □remarried
□divorced □separated □widowed
□significant other □living together □not currently in a relationship

Relationship satisfaction:

□very satisfied □satisfied □somewhat satisfied
□dissatisfied with relationship □very dissatisfied

Education (highest achieved):

□grade school or junior high □attending/attended college □technical school degree
□attending/attended high school □college graduate □graduate degree (Masters)
□high school graduate □attending/attended graduate school □graduate degree (Doctoral)

Military Service branch _____ years served_____ combat □yes □no Type of discharge: _____

Describe any arrests, convictions, court-ordered treatment, parole, probation, jail or prison sentences: _____

_____

_____

What do you claim as your cultural or ethnic identity?: _____

What was your religious orientation as a child (if any)?: _____

What is your religious orientation as an adult (if any)?: _____

Friendships:

Do you make friendships easily? □yes □no
Do you have difficulty maintaining friendships? □yes □no
What's your comfort level in social situations _____
How many close or "best friends" do you have _____

Sexuality:

□heterosexual orientation □same-sex orientation □bisexual orientation
□currently sexually active □not currently sexually active □currently sexually satisfied
□currently sexually dissatisfied □age first experienced sex _____ □age of first pregnancy/fatherhood _____
□history of promiscuity □history of unsafe sex

What hobbies or special interest do you currently have?: _____

Describe any current housing conditions or living arrangements that might be considered unusual?: _____
_____
_____

WHAT BRINGS YOU TO INSIGHTS?

Who referred you to Insights?: _____

May we contact that person and say thank you? □yes □no

Briefly describe what brought you to Insights: _____
_____
_____

How concerned are you about the problem(s) that brought you to Insights?
□no concern □little concern □moderate concern □serious concern □very serious concern

Motivation for coming to Insights:
□self-motivated
□other-motivated
□threat of partner leaving relationship
□to keep job, stay in school, live at home
□to keep professional license
□child custody is a significant factor
□condition of probation or parole
□other_____

What do you hope to accomplish in therapy?: _____
_____
_____

Have you ever been seen for counseling or therapy, alone or with someone else? □yes □no
If yes, describe: _____
_____

Insights is a training facility. Do you consent for a Masters/Ph.D. Level Intern to sit in on your sessions from time to time?
□yes □no

MEDICAL/EMOTIONAL INFORMATION

Primary Physician's Name: _____ Phone: _____
If we think it is appropriate, may we contact your physician to discuss your case? □yes □no

Psychiatrist's Name: _____ Phone: _____

If we think it is appropriate, may we contact your psychiatrist to discuss your case? □yes □no

Date of last physical: _____

What medications (prescribed and over-the-counter) are you taking and for what purpose?

Medication	Purpose	When started	Prescribed By

(Use the back of this page if there are additional medications)

Please list all your medical treatments and operations within the last year: _____

_____

Please list all your current illnesses or disabilities (e.g., allergies, ulcers, back problems, skin disorders, etc.): _____

_____

Please list any learning disabilities: _____

Have you or others ever been concerned about your alcohol or other substance use? □yes □no

Have you ever lost a friendship, relationship or job because about your alcohol or other substance use? □yes □no

Have you experienced legal consequences due to alcohol or other substance use/possession? □yes □no

Are you presently concerned about your alcohol or other substance use? □yes □no

Which of the following have you consumed in the last year?

Alcohol □yes □no if yes, how much and how often? _____

Amphetamines □yes □no if yes, how much and how often? _____
(meth, ice, crank, etc.)

Cocaine □yes □no if yes, how much and how often? _____

Crack □yes □no if yes, how much and how often? _____

Hallucinogens □yes □no if yes, how much and how often? _____
(LSD, mushrooms, etc.)

Inhalants □yes □no if yes, how much and how often? _____

Marijuana □yes □no if yes, how much and how often? _____

Opiates □yes □no if yes, how much and how often? _____
(heroin, Vicodin, Oxy, etc.)

Sedatives □yes □no if yes, how much and how often? _____

Tranquilizers □yes □no if yes, how much and how often? _____
(valium, Xanax, etc.)

Designer Drugs □yes □no if yes, how much and how often? _____
(X, GHB, etc.)

Over the Counter □yes □no if yes, what, how much and how often? _____

Women:

Age at first period _____

Are your periods regular? □yes □no

Do your periods affect your mood? □yes □no

Hysterectomy □yes □no

Menopause □yes □no

Perimenopause □yes □no

Hormone replacement □yes □no

Number of pregnancies _____

Number of miscarriages: _____

Number of abortions: _____

Do any of these behaviors apply to you?

History of violent behavior
□yes □no If yes, describe_____

Suicide attempts
□yes □no If yes, describe_____

Suicide plans
□yes □no If yes, describe_____

Suicidal thoughts
□yes □no If yes, describe_____

Sexual abuse
□yes □no If yes, describe_____

Physical abuse
□yes □no If yes, describe_____

Emotional abuse
□yes □no If yes, describe_____

Have you ever been hospitalized for an emotional disorder, eating disorder, chemical dependency, etc.?
□yes □no If yes, describe_____

Briefly list what you think are your personal strengths and weaknesses (personality, character, intellect, skills, talents, achievements, etc.)

Strengths	Weaknesses

Describe any current housing conditions or living arrangements that might be considered unusual? _____
_____
_____

Check any of the following that apply to you:

□Palpitations	□Fatigue/low energy	□Poor concentration
□Poor grooming	□Mood swings	□Feel panicky
□Racing thoughts	□Sexual problems	□Feel lonely
□Feel inferior	□Anger	□Children having problems
□Career problems	□Unable to sit still	□Loss of interest in sex
□Fainting spells	□Nightmares	□Feeling depressed
□Difficulty making or keeping friends	□Education	□Easily distracted
□Spouse problems	□Problems w/ prescription drugs	□Problems with alcohol
□Abuse of non-prescription drugs	□Blackouts/temporary memory loss	□Excessive sleeping
□Feeling "on top of the world"	□Inability to control thoughts	□Feeling "numb" or cut off from emotions
□Compulsive sexual behavior	□Dizziness	□Appetite loss or increase
□Bedwetting	□Insomnia	□Tremors
□Sexual trauma	□Difficulty having fun	□Poor home environment
□Legal problems	□Self-control	□Parenting difficulties
□Lose time	□Compulsive behavior	□Divorce
□Bowel disturbances	□Unable to relax	□Memory problems
□Financial problems	□Hyperactivity	□Feeling fat
□Suspicious of other people	□Crying spells	□Hearing voices
□Lack of motivation	□Excessive boredom	□Relationship problems
□Procrastination	□Drink too much	□Work too hard
□Suicidal thoughts	□Aggressive behavior	□Odd behavior

□Nervous tic	□Trouble sleeping	□Trouble keeping job
□Take too many risks	□Agitation/irritability	□Anxiety
□Phobias/fears	□Oppositional	□Social isolation
□Hopelessness	□Grief	□Physical pain
□Self-injury	□Hallucinations	□Anorexia
□Bingeing/purging	□Excessive laxative or diuretic use	□Emotional trauma
□Substance abuse	□Anxiety attacks	□Physical trauma

Is there anything we have forgotten to ask that you think is important for us to know about you? _____

_____

_____

_____

Client signature Date