

New Client Information and History

Welcome to *Soundview Health Associates*. Please complete this **Information and History** form as a way of orienting your psychologist to your needs. Be sure to complete both sides of the form.

During our first intake evaluation session, your reasons for seeking therapy will be discussed, as well as your personal and family health history. Any information relevant to understanding your situation, including past treatment you've sought, will be extremely helpful to our process. You'll know best what the full story is, so you don't need to limit our conversation to the areas on this history form or the things I ask you about specifically.

It may be that you decide as part of our early session(s) that you would prefer to see someone different, or it may be that I believe it best to refer you to someone else for ongoing care; this is a normal part of the process. Neither party need feel badly if the match isn't right. (In fact, for psychologists, this is part of our code of ethics.)

Full Name: _____ Date: _____

Gender _____ Birthdate _____ Ethnicity(ies) _____

Relationship status: _____

Others Living at home: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

My I mail to you at this address? Yes _____ No _____ May I E-mail you? Yes _____ No _____

Phone: Home (____) _____ Wk (____) _____ Cell (____) _____

May I contact you and leave messages at these phone numbers? Which one(s)? _____

Your preference(s) for being contacted with a confidential message?: _____

In case of emergency, contact: _____ Phone: (____) _____

Relationship to contact: _____

Employer: _____ How long have you worked there? _____

Occupation: _____ How long in this occupation? _____

Education (highest level attained): _____

Primary Care Physician: _____ Phone: _____

Please list any significant health problems: _____

List any medications you are taking & the dosage: _____

Have you ever met with a psychologist, psychiatrist, counselor or social worker in the past? Yes ____ No ____

(If Yes) When and with whom? _____

Please give a brief description of treatment: _____

Please list any medications for emotional health issues that you've been prescribed in the past (if any): _____

Ever been hospitalized or received intensive treatment for emotional health concerns? Yes ____ No ____

If so, for _____ on (approximate date) _____

How did you learn of this therapy practice? _____

Who may we thank (if anyone) for referring you? _____

Will you use health insurance to pay for services? Yes ____ No ____ [If not, skip questions about insurance]

Insurance company _____ Do you have a limited # of sessions? Yes ____ No ____

Policy holder's name _____ Policy holder's DOB: _____

SSN or Identification #: _____ Your relationship to policy holder _____

Please check the statement that best describes how you're doing right now:

- _____ I am functioning well, but I am seeking therapy for personal growth and life improvement.
- _____ I am functioning quite well, but I have some concerns I'd like to prevent from becoming bigger issues.
- _____ I am functioning relatively well, but I am not feeling good and could use help sorting things out.
- _____ I'm experiencing problems that are negatively affecting how well I function in major area(s) of my life.
- _____ I feel as though I'm barely functioning much of the time.

Please describe your reason(s) for seeking therapy at this time. If there is a particular event which triggered your decision to seek treatment now, please list/describe the event:

What result(s) do you expect or hope from therapy? _____

Please check all those items that help describe your concerns. Star the ones that are particularly important to you.

- | | |
|--|---|
| _____ Anxiety or nervousness in general | _____ Grief in response to a death or loss |
| _____ Panic attacks or intense fears | _____ Help adjusting to a change in my life |
| _____ Avoiding leaving your home or social anxiety | _____ Recovering from a trauma |
| _____ Personal growth issues | _____ Cultural identity |
| _____ Social skills or loneliness | _____ Sexual orientation |
| _____ Relationship issues | _____ Spiritual identity |
| _____ Family issues | _____ Gender identity |
| _____ Self-esteem | _____ Different identity issue: |
| _____ Eating patterns | _____ Feeling detached from the world |
| _____ Body image/weight concerns | _____ Imagining things that are not real |
| _____ Sexuality patterns, (in)experience or desire | _____ Conflict with a friend, colleague, employer |
| _____ Alcohol or drug use | _____ Physical abuse |
| _____ Desire to change a behavior | _____ Emotional or verbal abuse |
| _____ Managing impulses, making hasty decisions | _____ Sexual assault or abuse |
| _____ Managing anger | _____ Harassment |
| _____ Mood swings | _____ Struggling to perform in career or school |
| _____ Depression or feeling low | _____ Career planning issues |
| _____ Cutting, hitting, or burning yourself | _____ Perfectionism or procrastination |
| _____ Considering suicide | _____ AD/HD or a learning disability |
| _____ Sleeping too much or not enough | _____ Physical disability or illness |
| _____ Nightmares | _____ Other issue(s) Please describe: |
| _____ Chronic pain or fatigue | |
| _____ Stress Management | |

Thank you very much for completing this form.