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New Client Information Form

Name: ___________________________________ Preferred nickname/other: ____________________________________

Date: ___________________ Gender: ______________________ Date of birth: __________________ Age: _________

Home phone #: ________________ OK to leave message about appointments? Yes No Follow-up calls? Yes No

Cell phone #: _________________ OK to leave message about appointments? Yes No Follow-up calls? Yes No

Work phone #: ________________ OK to leave message about appointments? Yes No Follow-up calls? Yes No

Unless encrypted, email is not a secure form of communication. However, if it is OK to email you about appointments/follow-up, please provide your preferred email address and initial to grant consent: ___________________________________ Initial if OK: ________

Current Street Address: ____

Please check: Is this a house you own? _____ A house or apartment you rent? _____ The home of parents/relatives/friends? _____

Who lives with you? No one ____ Spouse/Partner ____ Child/Children ____ Parent(s) ____ Other: ____________________________

How long have you lived there? _____________ If less than one year, where did you live previously? ___________________________

____

Highest level of formal education: ___________ Currently in school? Y N If so, where? ________________________

Current Occupation and major job duties: ____

Employer: ____ Length of time with current employer: ____________

Previous employer if less than one year at current job: ____

Please check: Is your current job rewarding? _____ A major source of stress? ______ Consistent with career goals? _____

Any other work-related information that would be helpful for me to know? ____

How did you initially find out about my practice? Friend ____ Relative ____ Another Therapist/Medical Provider _____

Internet Search _____ (If so, was it: Psychology Today ____ GoodTherapy.org _____ Health Grades ____ BCBS _____

Theravive ___ Houston Psychological Association ____ Texas Psychological Association ____ National Register ____

ACBS _____ CounselingHouston.com ____ Dr. Chuck Gray's website _____ Other: ___________________________)

Do you have any particular religious or spiritual beliefs that would be helpful for me to know about? Y N

If yes, please explain: ____

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Where did you grow up? ____

Who primarily raised you during your childhood? Biological mother ____ Biological father ____ Both bio parents _____

Biological parent and step-parent/parent's partner(s)? _____ Maternal grandparent(s) _____ Paternal grandparent(s) _____

Adoptive parent(s) ____ Foster parent(s) ____ Other ____

	First name of family member	Age	Please provide any related info that would be helpful for me to know
Father	______________________	____	____
Mother	______________________	____	____
Other	______________________	____	____
Other	______________________	____	____
Sibling	______________________	____	____
Sibling	______________________	____	____
Sibling	______________________	____	____
Sibling	______________________	____	____

Current Relationship Status: Single (never married) ____ Casually Dating? Y N Engaged/Serious Commitment ____

Married/Partnered, but Separated ____ Divorced ____ (how many times? _____) Widowed _____ (for how long? _____)

Married/common-law/committed _____ (how many times? _____) If currently in any relationship, for how long? ________

Full name of spouse/partner (if any): ________________________________ Age: ______ Gender: ______________

Comments: ____

If you have children, please give their name, age, gender, and any other helpful info (e.g., biological/step/adoptive child, etc.)

Name of child	Age	Gender	Other information that would be helpful for me to know
__________________	_____	______	____
__________________	_____	______	____
__________________	_____	______	____
__________________	_____	______	____
__________________	_____	______	____
__________________	_____	______	____

Please provide any other information about your family that would be helpful for me to know:_________________

____

Name: ____

Primary issues you would like to address in our work together: ____

____

Person(s) to contact in case of an emergency:

Full Name: ______________________________ Relation: _____________________ Phone #: ____________________

Full Name: ______________________________ Relation: _____________________ Phone #: ____________________

May I contact him/her if needed? Y N If OK, please give phone # ____________________ and initial ________

Name of primary care physician: ___________________________________ Approx date of last appt: ____________

May I contact him/her if needed? Y N If OK, please give phone # ____________________ and initial ________

Please list any chronic health conditions or physical problems that I should know about: ____________________

____

Name of past/current psychiatrist: _________________________________ Approx date of last appt: ____________

May I contact him/her if needed? Y N If OK, please give phone # ____________________ and initial ________

Current medications: ____

Have you previously had any counseling? Y N Individual ____ Couples ____ Family ____ Group ____

If so, what helped the most: ____

If so, what was LEAST helpful: ____

Name of previous therapist: _____________________________________ Approx date of last appt: ______________

May I contact him/her if needed? Y N If OK, please give phone # ____________________ and initial ________

If you have health insurance and would like to use it, please ask one of our office managers to make a copy of your insurance card so they can call and verify your mental health benefits.

By signing below, I give Karen Waldman, Ph.D., and her clinical staff permission to consult with one another if needed and to call the above-mentioned emergency contact(s) in case of an emergency. A formal release of information form will be provided prior to contacting any other individuals.

___________________________________	___________________________________	_________________
Printed Name	Signature	Date