New Directions Client Information Form

A. Identification

Name: _____ Age: _____ Phone No. _____ Date: _____

Name and ages of family members: _____
_____

B. Chief Concern

Please describe the main difficulty that has brought you to see me: _____
_____
_____
_____
_____
_____
_____
_____

When did your problems begin? _____
_____

Have you ever seriously thought of killing yourself or hurting yourself, or have you ever made such an attempt? _____ Please give details. _____

Have you ever had a strong desire to seriously hurt someone, or have you ever made an attempt to do so? _____
Please give details. _____

C. Previous Treatment

Have you ever taken antidepressant or other medication for mental health issues? □ No □ Yes
Have you ever received psychological or psychiatric or counseling services before? □ No □ Yes

When?	From whom?	For what?	Medications Prescribed?	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

D. Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults present: _____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: _____
_____

E. Physical Health

1. Date of last physical and name of your doctor: _____

2. Current medical problems or illnesses: _____

3. Allergies: _____

F. Abuse History: □ I was not abused in anyway. □ I was abused.

If you were abused, please indicate the following: For kind of abuse, use these letters

P = Physical, such as beatings
S = Sexual, such as touching/molesting/fondling or intercourse.
N = Neglect, such as failure to feed, shelter or protect you.
E = Emotional, such as humiliation, etc.

Your Age	Kind of abuse	By whom?	Effects on you	Whom did you tell?	Consequences of telling
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

G. Present Relationships (if applicable)

How do you get along with your present spouse or partner? Children? _____
_____
_____

H. Chemical Use

1. Have you ever felt the need to cut down on your drinking? □ No □ Yes

2. Have you ever felt annoyed by criticism of your drinking? □ No □ Yes

3. Have you ever felt guilty about your drinking? □ No □ Yes

4. Have you ever taken a morning "eye opener"? □ No □ Yes

5. How much beer, wine or hard liquor do you consume each week, on the average? _____

6. How much tobacco do you smoke or chew each week? _____

7. Which drugs (not medications prescribed for you) have you used in the last 10 years? _____
_____

8. How many caffeinated beverages do you consume in a day? _____

I. Legal History

Briefly describe any history of arrests and convictions (either felonies or misdemeanors), including any moving violations while in an automobile. _____

J. Religious Background and Beliefs

Please indicate your religious background and current beliefs. _____