Renewing Hope
COUNSELING SERVICE

NEW CLIENT HISTORY FORM

Client Name: _____ **Date:**_____

Presenting Issue(s):

_____

_____

_____

Mental Health Information

Most recent Mental Health Provider:

Name: _____ Phone: _____

Dates Attended: _____

May we contact them: Yes No

Focus of Therapy: _____

_____

Reason for stopping: _____

_____

Prior Diagnosis: _____

_____

Did you experience any developmental issues as a child (walking, talking, etc)? Yes No

If yes, please explain: _____

_____

Have you ever had psychological testing performed? Yes No

Have you ever been placed out of home or stayed in the hospital for mental health reasons? Yes No

If so, please provide dates and age: _____

_____

Has anyone in your family been diagnosed with a mental illness? Yes No If yes, please explain: _____

_____

Medical Information

Current Medical Providers:

Name: _____ Phone: _____

May we contact them: Yes No

Medical Conditions/ History: _____

_____

Current Medications: _____

Do you have any allergies? Yes No If yes, please list below along with known reactions: _____

_____

Has anyone in your family been diagnosed with a medical disease? Yes No If yes, please explain: _____

_____

Substance Use Information

Do you drink alcoholic beverages? Yes No If yes please list how many drinks per setting, per week:_____

Do you use illegal substances? Yes No

If yes please list: _____

Do you use prescribed medications not prescribed to you? Yes No

If yes please list: _____

Has anyone in your family struggled with substance/ alcohol abuse: Yes No

If yes, please explain: _____

_____

Do you use product which contain nicotine? Yes No

If yes please list: _____

If you circled yes to nicotine use, would you like nicotine cessation information? Yes No