Center for Counseling, Growth & Discovery, LLC

The Sound Room at Polaris

New Client Information Form Date:_____

First Name: _____ Middle:_____ Last:_____

Street Address: _____ Apt:_____

City:_____ State:_____ Zip:_____

Phone: Home _____ Work: _____ Cell:_____

Date of Birth: _____ Email: _____

May I leave a voicemail msg? _____ Leave a txt? _____ Leave an email? _____

How did you find out about CCG&D ? _____

Emergency Contact:

Name: _____ Relationship_____ Phone:_____

Consent to contact in case of an emergency or imminent threat? _____

Goals for Counseling: _____

Members Living in the Household

Name	Relationship	Age	Quality of Relationship

Other Significant Individuals NOT Living in the Household

Name	Relationship	Age	Quality of Relationship

Employment History

Are you currently employed outside the home? _____ Place of employment_____

Occupation _____ Number of jobs in the past five years _____

Education History – When, Where? _____

Health History

Primary Care Physician _____

Address: _____

Phone: _____ Date of Last Exam _____

	You	Relative	Never	Past	Current	Notes
Auto Immune						
Cancer						
Cirrhosis						
Diabetes						
Epilepsy						
Heart Problems						
High Blood Pressure						
HIV/AIDS						
Hepatitis						
Headaches						
Low Blood Sugar						
Stroke						
Ulcers/Stomach/Bowel						
Other						

Allergies: _____

Current Medications

Medication	Dosage	Frequency	Purpose	Prescribed By:

Have you ever experienced head trauma? _____

_____

Major changes in the last 12 months: _____

Does Spirituality/Religion play a part in your life?_____

Mental Health History

	Never	You	Family	Past	Current	Notes
Nervous, Worried, Tense, Panic						
Sad, Down, Lacking Motivation						
Trouble Concentrating/ Lack focus						
Trouble Sitting Still						
Domestic Violence						
Appetite, Weight Gain/Loss						
Intense/Explosive Anger						
See/Hear/Smelled Things Not Real						
Excessive Goal Directed Energy						
Problems with Traumatic Events						
Suicidal Thoughts or Actions						
Self-Mutilation						
Substance Abuse						
Obsessive/Compulsive Rituals						
Trouble Falling/Staying Asleep						
Recurring Dreams or Nightmares						

Is there anything you would like me to know about your gender identity or sexual orientation?

_____

Abuse History

Physical Abuse Yes No Sexual Abuse Yes No

Emotional Abuse Yes No Traumatic Events Yes No

Legal History

Do you have a history of legal charges? Yes No _____

Are you currently on probation or parole? Yes No _____

Is treatment court ordered? Yes No _____

Prior Treatment? Mental Health Yes No Drug/Alcohol Yes No

Explain:_____

Additional Info: _____

_____

Client Signature: _____ **Date:**_____