

**New Choices Counseling**  
**CLIENT INFORMATION**

Client Name: \_\_\_\_\_ DoB: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone #: \_\_\_\_\_ (OK to leave a message?) (Ok to text?)  
(Y\_\_ N\_\_) (Y\_\_ N\_\_)

Emergency Contact Person: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Contact phone #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

Amount Responsible for/Copay: \_\_\_\_\_

1) Please describe your reasons for seeking therapy at this time. If there is a particular event or situation which triggered your decision, please describe the event:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) What would you like to see accomplished in therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Have you or other members of your family ever received counseling or mental health services before? If so, please list dates, length of treatment, the issue for which services were sought, and what you feel was accomplished:

---

---

---

---

---

---

4) Have you ever been hospitalized for psychiatric reasons? If yes please explain:

---

---

---

---

5) Please list any major medical problems:

---

---

6) Please list any medication you are taking:

---

---

7) Please list any current or past legal or criminal history you may have:

---

---