NEW CLIENT INFORMATION

Irenic Counseling
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Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name: _____ _____ _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____ _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

Email: _____ May we email you? □ Yes □ No

Please note: Email correspondence is not considered to be a confidential medium.

How did you find out about my practice: _____

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Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____
__

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

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4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No

□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?

□ No

□ Yes

If yes, when did you begin experiencing this? _____ _____

7. Are you currently experiencing any chronic pain?

□ No

□ Yes

If yes, please describe: _____ _____

8. Are you currently having any thoughts involving intent to harm yourself or others?

□ No

□ Yes

If yes, please explain:

_____

_____

_____

9. Do you drink alcohol more than once a week? □ No □ Yes

10. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

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11. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____ _____

On a scale of 1-10, how would you rate your relationship? _____

12. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be your strengths in helping you in the therapeutic process?

_____

_____

_____

_____

4. What do you consider to be some of your challenges?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____