Somatic Psychotherapy

NEW CLIENT INFORMATION FORM

Name (Last, First, Middle) _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Home _____ Work _____ Mobile _____

Other _____ Where can I leave messages? _____

Birth Date _____ Age _____ Childhood Nicknames _____

Gender _____ Sexual Orientation _____

Relationship Status ☐ Married ☐ Never Married ☐ Widowed ☐ Single
☐ Divorced ☐ Separated ☐ Living Together As Partners

If married, duration of present marriage _____ Are there children living at home? ☐ Yes ☐ No

Names and ages of children _____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____

Spouse / Partner's Name _____ Age _____

Previous Marriages (Date / How ended) _____

Employer / School _____ Occupation _____

Education / Training (Highest Level Attained) _____

Previous Vocations _____

Military Service ☐ Yes ☐ No Dates _____ Did you serve in combat? ☐ Yes ☐ No

Have you had previous therapy? ☐ Yes ☐ No Spiritual or pastoral counseling? ☐ Yes ☐ No

When? _____ With whom? _____

Are you presently seeing a therapist? ☐ Yes ☐ No If yes, whom? _____

List past inpatient, intensive outpatient mental health, or drug/alcohol treatment you have received:

_____

List mental health diagnoses you have received _____

List past or present legal involvement _____

List mind-altering substances you have used in the past _____

Do you use any mind-altering substances currently? ☐ Yes ☐ No

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If you or others have concerns about your use of substances, please describe _____

_____

Have you suffered abuse or other trauma? ☐ Yes ☐ No

Your Physician's Name _____ Date of last medical exam _____

Are you currently on medication? ☐ Yes ☐ No

If so, which medication(s)? _____

Prescribed by _____ Major surgeries in the past five years? ☐ Yes ☐ No

For which condition(s)? _____

Other health conditions _____

What is your current physical condition? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

What is your current emotional condition? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Which of the following describe or relate to the concerns that bring you here?

☐ Aging Issues
☐ Anger
☐ Alcohol / Drugs
☐ Anxiety
☐ Eating / Food
☐ Faith
☐ Fear
☐ Finances
☐ Frequent Crying
☐ Gender Identity
☐ Grief
☐ Guilt
☐ Hopelessness
☐ Identity
☐ Legal Issues
☐ Life Transition
☐ Loneliness
☐ Meaning
☐ Mid-Life Issues
☐ Physical Health
☐ Poor Appetite
☐ Religious Doubts
☐ Self-Doubt
☐ Self-Esteem
☐ Self-Loathing
☐ Sexual Concerns
☐ Sleep Disturbances
☐ Suicidal Feelings
☐ Vocation/Career Issues
☐ Weight Loss

Relationship with:

☐ Partner
☐ Parents
☐ Children
☐ Others

Abuse issues:

☐ Sexual
☐ Physical
☐ Emotional
☐ Verbal

State in your own words the concerns that bring you to therapy _____

_____

_____

How will you know when your current concerns are resolved? _____

_____

_____

Emergency Contact _____ Phone _____ Relationship _____

How did you hear about me? _____