

# New Client Form (Adult)

Date \_\_\_\_\_

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

## General Client Information

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Soc. Security # \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Ethnic/Cultural Background: \_\_\_\_\_ Religion: \_\_\_\_\_

Native Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about LifeWorks? \_\_\_\_\_

## Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Has anything happened that may have brought on/intensified the problems you are experiencing?  Yes  No  
If yes, please explain: \_\_\_\_\_
- When (month/year) did you first begin to experience these problems? \_\_\_\_\_
- How many days, weeks, months, or years have you been experiencing these problems? \_\_\_\_\_
- How much is/are the problem(s) affecting you?  Mildly  Moderately  Severely
- In what areas do your problems impact your life? (Check all that apply)
  - Lifestyle (the way you live your life)
  - Activities (things you normally do or would like to do)
  - Relationships (your ability to form or maintain relationships with others)
  - Eating
  - Sleeping
  - Mood
- Have you ever attempted suicide?  Yes  No (If yes, when? \_\_\_\_\_)
- Have you been thinking about suicide?  Yes  No
- Have you ever experienced or witnessed a traumatic event?  Yes  No  
If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Have you had a significant loss or had someone close to you die?  Yes  No

## Life Questions

- Please list the current prescription and over-the-counter medications you are currently taking:
- Please list any medical issues you are experiencing:
- Problems or changes in my family or other important interpersonal relationships (include name of person and relationship):
- If you were to live life over, what person or event would you prefer to skip?
- What makes you angry and why?
- What was the last time you cried and why?
- What is your biggest regret or sadness?
- What is missing in your life to make it ideal?
- Who would be upset if you were completely "healed"?
- What do you wish you had never done?
- What is one positive goal you would like to achieve?
- How would your life be different if/when we handle all of your issues?
- What would you like to change in your life?

- What else do you want me to know:

### Symptom Checklist

**Directions:** Place a check next to any problems that are impacting your life. Next to the checkbox, rate how much it is affecting

<input type="checkbox"/>	Depression	<input type="checkbox"/>	Performing unusual rituals or habits
<input type="checkbox"/>	Low energy	<input type="checkbox"/>	Impulsiveness

you on a scale of 1 – 10 with 1 meaning its impact on your life is very little, and 10 meaning its impact is tremendous.

<input type="checkbox"/>	Low self-esteem	<input type="checkbox"/>	Excessive behaviors (Examples: spending, gambling)
<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	Delusions / hallucinations (Thinking / believing / seeing / hearing unusual things)
<input type="checkbox"/>	Lack of interest/enjoyment in life	<input type="checkbox"/>	Sexual problems
<input type="checkbox"/>	Feeling hopeless	<input type="checkbox"/>	Self injurious behaviors
<input type="checkbox"/>	Feeling worthless	<input type="checkbox"/>	Shyness
<input type="checkbox"/>	Feeling guilty or shameful	<input type="checkbox"/>	Social skills
<input type="checkbox"/>	Sleep changes (more/less)	<input type="checkbox"/>	Social support (family/friends)
<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	Stealing
<input type="checkbox"/>	Bad dreams/nightmares	<input type="checkbox"/>	Strange, weird, or peculiar behavior
<input type="checkbox"/>	Feeling Ignored or Abandoned	<input type="checkbox"/>	Confusion/can't think clearly
<input type="checkbox"/>	Appetite changes (more/less)	<input type="checkbox"/>	Feeling "not real"
<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	Feeling detached from yourself
<input type="checkbox"/>	Thoughts of hurting self	<input type="checkbox"/>	Feeling "hyper"
<input type="checkbox"/>	Thoughts of hurting others	<input type="checkbox"/>	Financial problems
<input type="checkbox"/>	Isolating from others/social withdrawal	<input type="checkbox"/>	Grief/bereavement
<input type="checkbox"/>	Feelings of sadness/loss	<input type="checkbox"/>	Health problems
<input type="checkbox"/>	Weight problems	<input type="checkbox"/>	Impact of your problems on others
<input type="checkbox"/>	Stress	<input type="checkbox"/>	Losing track of time
<input type="checkbox"/>	Anxiety/tension/worry	<input type="checkbox"/>	Problems with memory
<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	Can't hold onto an idea
<input type="checkbox"/>	Heart racing	<input type="checkbox"/>	Anger/frustration
<input type="checkbox"/>	Chest pain or heaviness	<input type="checkbox"/>	Suspiciousness or mistrustfulness
<input type="checkbox"/>	Chills / hot flashes	<input type="checkbox"/>	Problems trusting others
<input type="checkbox"/>	Tingling/numbness	<input type="checkbox"/>	Easily irritated/annoyed
<input type="checkbox"/>	Pain	<input type="checkbox"/>	Aggressiveness
<input type="checkbox"/>	Fear of dying	<input type="checkbox"/>	Unpleasant thoughts that won't go away
<input type="checkbox"/>	Fear of going "crazy"	<input type="checkbox"/>	Bothered by recurring thoughts
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Job/career problems or indecision
<input type="checkbox"/>	Fears or phobias	<input type="checkbox"/>	Destruction of property
<input type="checkbox"/>	Obsessions/compulsions	<input type="checkbox"/>	Self-criticism
<input type="checkbox"/>	Perfectionist behavior	<input type="checkbox"/>	Use of alcohol
<input type="checkbox"/>	Lying	<input type="checkbox"/>	Use of drugs
<input type="checkbox"/>	Making/keeping friends	<input type="checkbox"/>	Blackouts
<input type="checkbox"/>	Arguing with others	<input type="checkbox"/>	Physical abuse
<input type="checkbox"/>	Trouble with the law	<input type="checkbox"/>	Sexual abuse
<input type="checkbox"/>	Family problems	<input type="checkbox"/>	Partner abuse
<input type="checkbox"/>	Marital/relationship problems	<input type="checkbox"/>	Thoughts racing
<input type="checkbox"/>	Parent/child problems	<input type="checkbox"/>	Disorganization