Doorways, LLC

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New Client Information for Adults (18+)

Today's Date: _____ **How did you find us?** _____

I. Client Information

Legal Name: _____ Preferred Name/Nickname: _____

Birth Date: _____ Age: _____ Social Security #: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Email Address: _____

How would you like us to contact you?

Phone _____ □ Voice □ Text (for automated reminders ONLY)

Email _____ □ Yes □ No

Emergency Contact Information:

	Name:	Relationship:	Phone:
1.	_____	_____	_____
2.	_____	_____	_____

Please complete this section for others residing in the client's primary residence:

Name	Date of Birth	Age	Relationship to Client	Gender	Relevant Medical History

II. Client Occupational/Educational Status

Currently employed? □ Yes □ No If yes, □ Full-Time □ Part-Time Occupation: _____

If you're not employed, please check any of the following □ Unemployed □ Student □ Other _____

If you're a student, please tell us which school you attend: _____

III. Client's Health Status

Current or chronic medical issues: _____

Primary Care Provider: _____ Phone: _____

IV. Client Background Information

*The following information is **optional** but will help us to better serve you.*

Marital Status	
☐ Single	☐ Separated
☐ Living Together/Not Married	☐ Divorced
☐ Married	☐ Widowed

Sexual Orientation	
☐ Heterosexual	☐ Transgendered
☐ Gay/Lesbian	☐ Not sure/questioning
☐ Bisexual	

V. Client's Medication History

Are you **currently** taking any medications for emotional/substance abuse problems? ☐ YES ☐ NO

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:
Dates Used:	Dates Used:	Dates Used:

Have you **previously** taken any medications for emotional/substance abuse problems? ☐ YES ☐ NO

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:
Dates Used:	Dates Used:	Dates Used:

Other medications: _____

Prescribing Provider: _____ Phone: _____

VI. Client's Mental Health History

Have you had prior mental health related services? ☐ YES ☐ NO

	Therapist Name/Facility	**Phone #**	**Date**	**Duration**
Prior Therapy	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.
Prior Hospitalization(s)	1. 2. 3.	1. 2. 3.	1. 2. 3.	1. 2. 3.

VII. Presenting Problems/Life Stressors (please check all that apply):

- ☐ Abuse/trauma
- ☐ Alcohol/Drug abuse
- ☐ Anger/Irritability
- ☐ Anxiety/Stress
- ☐ Compulsive behaviors
- ☐ Depression/Sadness
- ☐ Difficult relationships
- ☐ Eating/Food Issues
- ☐ Fears/Worries
- ☐ Hallucinations
- ☐ Legal problems
- ☐ Loss of job(s)
- ☐ Low self esteem
- ☐ Medical/Physical complaints
- ☐ Memory difficulties
- ☐ Moves/Change of school
- ☐ Recent loss/Death
- ☐ Repeated bothersome thoughts
- ☐ Self-harm/Cutting
- ☐ Separations/Divorce
- ☐ Sleep difficulties
- ☐ Suicidal thoughts
- ☐ Trouble thinking/ Concentrating
- ☐ Weight loss or gain
- ☐ Other _____
- _____
- _____
- _____
- _____
- _____

Please briefly describe the reason for seeking counseling/psychiatric services at this time.

_____

_____

_____

_____