

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 to receive your courtesy reminder? (please choose only one)

Email Text Message Voice Message

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	
<input type="checkbox"/> Single	<input type="checkbox"/> Separated
<input type="checkbox"/> Living Together/Not Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed

Sexual Orientation	
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Transgendered
<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> Not sure/questioning
<input type="checkbox"/> 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.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.

Prior Hospitalization(s)	1.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.

Have you had a previous mental health diagnosis? YES NO

If *yes*, please list them below:

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

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

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