Doorways, LLC

4747 N. 7th St., Suite 450, Phoenix, AZ 85014
Office: 602.997.2880 Fax: 623.399.4013
www.doorwaysarizona.com

New Client Information for Adults (18+)

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

I. Client Information

Legal Name: _____ Nickname: _____ Birth Date: _____

Age: _____ Social Security #: _____ Gender Male☐ Female☐ Other _____

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: _____

Revised 02.13.2020

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.	1.	1.	1.
	2.	2.	2.	2.
	3.	3.	3.	3.

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

_____

_____

_____

_____