

# 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: \_\_\_\_\_ Nickname: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Gender  Male  Female  Other \_\_\_\_\_

Preferred Pronoun if applicable (**Circle one**): He/Him | Her/She | They/Them

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"/> Pansexual
<input type="checkbox"/> Gay/Lesbian	<input type="checkbox"/> Not sure/questioning
<input type="checkbox"/> Bisexual	<input type="checkbox"/> _____

**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.

<b>Prior Hospitalization(s)</b>	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:

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

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

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

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