Doorways, LLC

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New Client Information for Adults (18+ yrs)

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: 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: _____

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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	☐ Pansexual
☐ 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.

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.

_____

_____

_____

_____

_____

VIII. Substance Use Assessment (please complete in full if applicable):

Please check any substances you have used (if applicable):

☐ Acid
☐Alcohol
☐Cigarettes
☐Cocaine/Crack
☐Ecstasy
☐Heroin
☐Inhalants
☐Marijuana
☐Meth/Crystal
☐Mushrooms
☐PCP
☐Prescription pills
☐Other (i.e., cough med, herbal, salvia, etc.)
_____

Complete the following for any substances used more than 1 time:

Substance	Age 1st Used	How long used	How Often	How Much	Last Time Used

Substance Use Assessment Continued

1. I use alcohol or drugs to get away from things that bother me.	☐Yes	☐No
2. I use alcohol or drugs to solve my problems.	☐Yes	☐No
3. I need more or stronger kinds of alcohol or drugs to produce the same feeling, I used to get.	☐Yes	☐No
4. Sometimes after using I forget what happened.	☐Yes	☐No
5. Sometimes I hide my drinking or drug using from others.	☐Yes	☐No
6. I need alcohol or drugs to have fun.	☐Yes	☐No
7. Other people have complained about my drug use.	☐Yes	☐No
8. I feel guilty about my drug or alcohol use.	☐Yes	☐No
9. I feel bad about how my using hurts other people.	☐Yes	☐No
10. I make promises to change and then fail to do so.	☐Yes	☐No
11. I have made efforts in the past to change.	☐Yes	☐No
12. I try to control my drug or alcohol use.	☐Yes	☐No
13. I change jobs or relationships to make my life better.	☐Yes	☐No
14. My drug or alcohol use has caused health, legal, work, or relationship problems in my life.	☐Yes	☐No
15. I have experienced withdrawal symptoms.	☐Yes	☐No
16. I've said or done things I wouldn't normally do when using drugs or alcohol.	☐Yes	☐No
17. Drugs or alcohol have become a focus of my life.	☐Yes	☐No

Identify the response below that best represents your current level of willingness to change your substance use habits:

☐I don't want to change
☐Considering change
☐Ready to change
☐Making changes
☐Changes have been maintained for 3 or more months