

PAUL VANCE, LMFT (MFC 39530)
New Client Information and History

Date of Intake _____ Client's Date of Birth _____

Name of Client(s) _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell (____) _____ Email _____
Is it okay to contact you at home? (Circle) Yes No

Occupation _____ Employer _____ Education _____

Marital Status (Circle): Single; Shared Living; Married; Divorced; Widowed; 2nd Marriage. Years Married ____

Previous Counseling/Hospitalization (Circle): Yes/No Approximate Date(s) _____ Duration _____

Medical doctor: _____ (____) _____
Name Phone Date of last physical

Current Medical Conditions: _____

Current Medications: _____

In Emergency contact: _____
Name & Relationship Phone

How were you referred? _____

For what concerns are you seeking counseling at this time? How long has this been a concern for you?

Current sources of stress:

Describe the events or interactions that precipitated your concerns?

Please check those that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> High stress |
| <input type="checkbox"/> Eating disturbance | <input type="checkbox"/> Anger/temper | <input type="checkbox"/> Social skills problems |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Gender issues | <input type="checkbox"/> Relationship issues |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Alcohol/drug abuse | <input type="checkbox"/> Low energy/fatigue |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Co-dependency |
| <input type="checkbox"/> Phobia/fears | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Sexual disturbance |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Aggressive Behaviors | <input type="checkbox"/> Obsessive/Compulsive Issues |
| <input type="checkbox"/> Avoidant behaviors | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Grief/Loss |
| <input type="checkbox"/> Other (please specify) _____ | | |
| <input type="checkbox"/> Present/past substance use (please specify substance(s) _____ | | |
| How often do you use the substance: ___/day ___/week ___/month | | |

Current Household Members (Name, Age, Relationship):

_____	_____
_____	_____
_____	_____
_____	_____

Who were the members of your childhood family? List names and relationship (mother, brother, sister etc)

_____	_____
_____	_____
_____	_____
_____	_____

Did anyone in your childhood family have a substance abuse problem? (Please describe)

Was there a history of mental illness in your childhood family? (Please describe)

Was there a history of physical or sexual abuse in your childhood family? (Please explain)

How do you hope that counseling will improve your relationships?