NANI WADDOUPS, LPC Date:
Mental Health Counseling
New Client Information

NAME: _____
ADDRESS: _____
_____
_____
OK TO RECEIVE MAIL? ○ YES ○ NO

DATE OF BIRTH: _____

BEST PHONE: _____
OK TO LEAVE MESSAGE? ○ YES ○ NO

E-MAIL ADDRESS: _____
OK TO RECEIVE EMAIL? ○ YES ○ NO

HAVE YOU HAD COUNSELING BEFORE? ○ YES ○ NO
IF SO, PLEASE BRIEFLY DESCRIBE YOUR EXPERIENCES:

PLEASE DESCRIBE **WHAT BRINGS YOU TO COUNSELING NOW:**

WHAT SEEMS TO TRIGGER OR MAKE THESE ISSUES WORSE? WHAT SEEMS TO HELP?

DESCRIBE ANY **RELATIONSHIP ISSUES** YOU MAY WISH TO EXPLORE IN COUNSELING:

MARITAL/RELATIONSHIP STATUS:
○ DIVORCED ○ SINGLE ○ LIVING TOGETHER ○ SEPARATED
○ WIDOWED ○ MARRIED ○ DOMESTIC PARTNERSHIP ○ OTHER

TOTAL NUMBER OF MARRIAGES/DOMESTIC PARTNERSHIPS: _____

PLEASE INDICATE YOUR CURRENT LEVEL OF RELATIONSHIP SATISFACTION:
○ VERY UNSATISFIED ○ SATISFIED ○ VERY SATISFIED

DO YOU HAVE CLOSE FRIENDS? SIGNIFICANT PEOPLE ? PLEASE DESCRIBE BRIEFLY:

DESCRIBE ANY **PARENTING ISSUES** YOU MAY WISH TO EXPLORE IN COUNSELING:

CHILDREN:
NAME: _____ AGE: _____ RELATIONSHIP: _____
NAME: _____ AGE: _____ RELATIONSHIP: _____
NAME: _____ AGE: _____ RELATIONSHIP: _____
NAME: _____AGE: _____ RELATIONSHIP: _____
NAME: _____ AGE: _____ RELATIONSHIP: _____

HAVE YOU EVER BEEN IN AN ABUSIVE RELATIONSHIP? ❍ YES ❍ NO

NATURE OF ABUSE (MARK ALL THAT APPLY)
❍ PHYSICAL ❍ VERBAL/PSYCHOLOGICAL ❍ SEXUAL ❍ RELIGIOUS
❍ FINANCIAL ❍ OTHER: _____

DO YOU FEEL SAFE IN YOUR CURRENT LIVING SITUATION? ❍ YES ❍ NO

WORK/EMPLOYMENT: ARE YOU WORKING NOW? ❍ YES ❍ NO

WHAT KIND OF WORK DO YOU DO OR WANT TO DO?

ARE THERE WORK ISSUES YOU WOULD LIKE TO DISCUSS? ❍ YES ❍ NO IF SO, PLEASE DESCRIBE:

DESCRIBE **ANY MEDICAL CONDITIONS** THAT IMPACT YOUR DAILY LIFE:

ARE YOU CURRENTLY TAKING ANY **MEDICATIONS FOR MENTAL HEALTH TREATMENT?**
❍ YES ❍ NO IF YES, PLEASE LIST YOUR CURRENT MEDICATIONS :

ARE YOUR CURRENTLY RECEIVING OTHER COUNSELING SERVICES?
❍ YES ❍ NO
IF YES, PLEASE DESCRIBE:

HAVE YOU EVER RECEIVED ANY MENTAL HEALTH DIAGNOSES? ❍ YES ❍ NO
IF YES, PLEASE DESCRIBE:

HAVE YOU EVER BEEN HOSPITALIZED FOR A PSYCHIATRIC CONDITION?
❍ YES ❍ NO

IF YES, PLEASE STATE THE DATE AND REASON FOR HOSPITALIZATION:

HAVE YOU EVER ATTEMPTED SUICIDE? ❍ YES ❍ NO

DO YOU CURRENTLY HAVE THOUGHTS OF HARMING YOURSELF?
❍ YES ❍ SOMETIMES ❍ NO

SUBSTANCES: CURRENT USE / BEHAVIORS / FREQUENCY (PER DAY OR WEEK)

CIGARETTES ❍ YES ❍ SOMETIMES ❍ NO _____
ALCOHOL ❍ YES ❍ SOMETIMES ❍ NO _____
MARIJUANA ❍ YES ❍ SOMETIMES ❍ NO _____
METH ❍ YES ❍ SOMETIMES ❍ NO _____
COCAINE ❍ YES ❍ SOMETIMES ❍ NO _____
OPIATES ❍ YES ❍ SOMETIMES ❍ NO _____
OVER-EATING ❍ YES ❍ SOMETIMES ❍ NO _____
UNDER-EATING ❍ YES ❍ SOMETIMES ❍ NO _____
GAMBLING ❍ YES ❍ SOMETIMES ❍ NO _____
CUTTING/SELF-INJURY ❍ YES ❍ SOMETIMES ❍ NO _____

HAVE YOU EVER RECEIVED TREATMENT FOR ADDICTIONS? ❍ YES ❍ NO
IF YES, PLEASE DESCRIBE:

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE ME TO KNOW ABOUT YOU?

I WRITE AN ALMOST-MONTLY NEWSLETTER. WOULD YOU LIKE TO BE ON MY MAILING LIST?
❍ YES ❍ NO