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Compassionate Counseling Services
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NEW CLIENT INFORMATION FORM
(total 3 pages)

General Information:

Date: _____ Referred by _____
 Client Name: _____
 Address: _____
 Home# _____ Work# _____ Cell# _____
 Fax# _____ Email _____
 Age _____ Date of Birth _____ Soc. Sec. # _____
 Occupation _____ Education Level _____
 Preferred appointment days and times : _____
 Emergency Contact Name _____
 Home# _____ Cell# _____ Relationship _____

Financial Information:

Method of payment: Cash _____ Check _____ Credit Card* _____ Insurance ** _____
 *Name on Credit Card _____ Expiration Date _____
 Credit Card Number _____
 Security Code (3- or 4-digit number on front or back of card) _____

** Please note that Compassionate Counseling Services (CCS) does NOT bill insurance companies directly.
 Upon request, CCS will provide a monthly invoice for therapy services rendered and paid for directly by client.
 Client is then responsible for obtaining reimbursement from their insurance company.

Household Information:

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Remarried _____
 Children (Names & Ages) _____

 Others living in household: _____
 Prior Counseling? _____ If yes, from (Date) _____ to (Date) _____
 Family Physician Name _____ Phone _____

Areas of Concern:

What issues/concerns caused you to seek treatment? Please describe: _____

What specific goals do you have with regard to your treatment? _____

What particular concerns/fears do you have with regard to treatment? _____

Psychological History:

Have you ever received counseling in the past? _____ If yes, from (date) _____ to (date) _____

What was the focus of counseling? _____

Names and phone #'s of treating therapist(s), _____

Have you ever been hospitalized for mental or emotional problems? _____ If yes, when and for how long? _____

Why were you hospitalized? _____

Are you currently taking any prescription or over-the-counter medications? _____ If yes, name and phone# of prescribing physician _____

Names and dosages of medications _____

How long have you been taking these medications? _____

Have you ever taken any medications for a mental or emotional condition? _____ If yes, when and for how long? _____

Name and phone# of prescribing physician _____

Have you ever attempted suicide? _____ If yes, when? _____

Please describe circumstances that led to that event _____

Are you currently having any suicidal thoughts? _____ Please describe _____

Please describe your childhood _____

Were you ever subjected to verbal, physical emotional or sexual abuse? _____ If yes, please describe _____

Have you ever been the victim of a violent crime? _____ If yes, please describe _____

Medical History:

Have you ever been diagnosed with a serious illness?_____ If yes, please describe_____

Do you have any medical conditions that may affect your mental health treatment?_____ If yes, please describe_____

Please describe your overall health today_____

Are you physically active?_____ If yes, please describe_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition?_____ If yes, please describe_____

Have you ever been in a 12-step program?_____ If yes, please describe_____

Do you smoke?_____ If yes, how many cigarettes per day?_____ For how long?_____

Do you drink alcohol?_____ If yes, how often?_____

How much do you consume each time?_____

Do you currently use illegal drugs?_____ If yes, please describe_____

Have you ever used illegal drugs?_____ If yes, please describe_____

Family History:

Mother’s name, age, living/deceased, client’s age at time of mother’s death, description of relationship with mother_____

Father’s name, age, living/deceased, client’s age at time of father’s death, description of relationship with father_____

Names and ages of siblings_____

Other Information:

Please describe your spiritual identity/orientation_____

Please describe your interests/hobbies_____

Have you ever been arrested?_____ If yes, please describe_____

Are you now or have you ever been involved in a lawsuit? If yes, please describe_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested_____