

**Rich Greeete, M.A., M.Div.**  
Licensed Mental Health Counselor MH 9297  
Christian Counseling

## Confidential New Client Information Form

### GENERAL INFORMATION

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Full Name: Mr. / Mrs. / Ms. / Miss / Dr. / Rev. \_\_\_\_\_

Nick Names: \_\_\_\_\_ Name You Prefer: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Ethnicity: White / Black / Hispanic / Asian / Other: \_\_\_\_\_ Sex: Male / Female

Street Address: \_\_\_\_\_ Suite Apartment # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

May we send mail here:  Yes /  No

Mailing Address or Post Office Box:  Same as above

Street Address: \_\_\_\_\_ Suite Apartment # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

May we send mail here:  Yes /  No

Home Phone: \_\_\_\_\_ Call you here?  Yes  No Message here?  Yes  No

Work Phone: \_\_\_\_\_ Call you here?  Yes  No Message here?  Yes  No

Cell Phone: \_\_\_\_\_ Call you here?  Yes  No Message here?  Yes  No

Email Address: \_\_\_\_\_ May We Send Email Here?  Yes  No

Employer: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Occupation: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

Average Annual Salary:  \$0 – 27,000  27,001 – 55,000  55,001 – 80,000  More Than 80,000

Last Year of School Completed:  9  10  11  12  GED College:  1  2  3  4 Other: \_\_\_\_\_

Are You Currently In School?  Yes  No If Yes, What Level: \_\_\_\_\_ Degree Pursuing: \_\_\_\_\_

Do You Regularly Attend A Place Of Worship?  Yes  No If Yes, Where? \_\_\_\_\_

### EMERGENCY CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## RELATIONAL INFORMATION

Current Marital Status:  Single  Dating  Engaged  Married  Separated  Divorced  Widowed

Are You Content with Your Current Status:  Yes  No If No, Briefly Explain: \_\_\_\_\_

If Dating, Engaged, Married, Separated, Divorced or Widowed, How Long: \_\_\_\_\_

Number of Previous Marriages for You: \_\_\_\_\_ For Your Partner: \_\_\_\_\_

Partner's Name: Mr. / Mrs. / Ms. / Miss / Dr. / Rev. \_\_\_\_\_

How Long Have You Known Your Partner: \_\_\_\_\_ Age: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Partner's Ethnicity: White / Black / Hispanic / Asian / Other: \_\_\_\_\_ Sex: Male / Female

Partner's Occupation: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

Education Partner Completed:  9  10  11  12  GED College:  1  2  3  4 Other: \_\_\_\_\_

What Words Would You Use to Describe Your Partner: \_\_\_\_\_

Is Your Partner Supportive of You Seeking Counseling:  Yes  No  Unsure  Partner Does Not Know

With Whom Do you Currently Live (*check all that apply*)  Alone  Spouse  Children  Parents  Sibling(s)

Boyfriend  Girlfriend  Roommate  Other: \_\_\_\_\_

## CHILDREN

List Your Children (including step, adopted, foster) below (use back if necessary):

Name	Sex	Current Age or Year of Death	Relationship to you (e.g., Natural, Adopted, Step)	Living With Whom?	Describe Him/Her

Have You Ever Placed a Child for Adoption?  Yes  No If Yes, When: \_\_\_\_\_

Have You Ever Had a Miscarriage or Medical Abortion?  Yes  No If Yes, when: \_\_\_\_\_

**FAMILY OF ORIGIN**

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling)	Occupation	Describe Him/Her

**MEDICAL INFORMATION**

Primary Physician: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

List Any Medical Conditions, Illnesses, Treatments, or Surgeries: \_\_\_\_\_

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Improves \_\_\_ Prevents \_\_\_ Controls \_\_\_\_\_

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: \_\_\_ Yes \_\_\_ No

Your Height: \_\_\_\_\_ Your Weight: \_\_\_\_\_

How Has Your Weight Changed in the Last 2 - 3 Months: \_\_\_\_\_

Are You Presently Experiencing Any Suicidal Thoughts? \_\_\_ Yes \_\_\_ No

Have You Ever Experienced them in the Past? \_\_\_ Yes \_\_\_ No

Have You Ever Attempted Suicide? \_\_\_ Yes \_\_\_ No If Yes, When and How: \_\_\_\_\_

Have Any of Your Friends or Family Ever Committed or Attempted Suicide? \_\_\_ Yes \_\_\_ No If Yes, When and Who: \_\_\_\_\_

## PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms / Sensations that Apply to You Presently, or in the Recent Past:

Headaches..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Dizziness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Stomach Trouble... <input type="checkbox"/> Past <input type="checkbox"/> Present
Visual Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Sleep Trouble..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Trouble Relaxing... <input type="checkbox"/> Past <input type="checkbox"/> Present
Weakness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Tension..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Rapid Heart Rate.... <input type="checkbox"/> Past <input type="checkbox"/> Present
Difficulty Breathing... <input type="checkbox"/> Past <input type="checkbox"/> Present	Intestinal Trouble... <input type="checkbox"/> Past <input type="checkbox"/> Present	Hearing Noises..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Change in Appetite.... <input type="checkbox"/> Past <input type="checkbox"/> Present	Tiredness..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Pain..... <input type="checkbox"/> Past <input type="checkbox"/> Present
Hearing Voices..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Seeing Things..... <input type="checkbox"/> Past <input type="checkbox"/> Present	Other..... <input type="checkbox"/> Past <input type="checkbox"/> Present

## PRESENT ISSUES

Please Check Any of the Following Physiological Symptoms / Sensations that You or Your Family Are Presently Experiencing:

Stress..... <input type="checkbox"/> You <input type="checkbox"/> Family	Nervousness..... <input type="checkbox"/> You <input type="checkbox"/> Family	Anxiety..... <input type="checkbox"/> You <input type="checkbox"/> Family
Panic..... <input type="checkbox"/> You <input type="checkbox"/> Family	Unhappiness..... <input type="checkbox"/> You <input type="checkbox"/> Family	Depression..... <input type="checkbox"/> You <input type="checkbox"/> Family
Guilt..... <input type="checkbox"/> You <input type="checkbox"/> Family	Apathy..... <input type="checkbox"/> You <input type="checkbox"/> Family	Terminal Illness..... <input type="checkbox"/> You <input type="checkbox"/> Family
Recent Death..... <input type="checkbox"/> You <input type="checkbox"/> Family	Grief..... <input type="checkbox"/> You <input type="checkbox"/> Family	Hopelessness..... <input type="checkbox"/> You <input type="checkbox"/> Family
Inferiority..... <input type="checkbox"/> You <input type="checkbox"/> Family	Defective Feelings... <input type="checkbox"/> You <input type="checkbox"/> Family	Loneliness..... <input type="checkbox"/> You <input type="checkbox"/> Family
Shyness..... <input type="checkbox"/> You <input type="checkbox"/> Family	Fears..... <input type="checkbox"/> You <input type="checkbox"/> Family	Friends..... <input type="checkbox"/> You <input type="checkbox"/> Family
Marriage..... <input type="checkbox"/> You <input type="checkbox"/> Family	Communication.... <input type="checkbox"/> You <input type="checkbox"/> Family	Physical Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family
Emotional Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family	Verbal Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family	Sexual Abuse..... <input type="checkbox"/> You <input type="checkbox"/> Family
Temper..... <input type="checkbox"/> You <input type="checkbox"/> Family	Anger..... <input type="checkbox"/> You <input type="checkbox"/> Family	Aggressiveness..... <input type="checkbox"/> You <input type="checkbox"/> Family
Bad Dreams..... <input type="checkbox"/> You <input type="checkbox"/> Family	Concentration..... <input type="checkbox"/> You <input type="checkbox"/> Family	Racing Thoughts..... <input type="checkbox"/> You <input type="checkbox"/> Family
Unwanted Thoughts... <input type="checkbox"/> You <input type="checkbox"/> Family	Memory..... <input type="checkbox"/> You <input type="checkbox"/> Family	Loss of Control..... <input type="checkbox"/> You <input type="checkbox"/> Family
Impulsive Behavior... <input type="checkbox"/> You <input type="checkbox"/> Family	Self-Control..... <input type="checkbox"/> You <input type="checkbox"/> Family	Compulsivity..... <input type="checkbox"/> You <input type="checkbox"/> Family
Sexual Problems..... <input type="checkbox"/> You <input type="checkbox"/> Family	Pregnancy..... <input type="checkbox"/> You <input type="checkbox"/> Family	Abortion..... <input type="checkbox"/> You <input type="checkbox"/> Family
Legal Matters..... <input type="checkbox"/> You <input type="checkbox"/> Family	Trauma..... <input type="checkbox"/> You <input type="checkbox"/> Family	Eating Problems..... <input type="checkbox"/> You <input type="checkbox"/> Family
Drug Use..... <input type="checkbox"/> You <input type="checkbox"/> Family	Alcohol Use..... <input type="checkbox"/> You <input type="checkbox"/> Family	Trouble with Job..... <input type="checkbox"/> You <input type="checkbox"/> Family
Career Choices..... <input type="checkbox"/> You <input type="checkbox"/> Family	Ambition..... <input type="checkbox"/> You <input type="checkbox"/> Family	Making Decisions... <input type="checkbox"/> You <input type="checkbox"/> Family
Children..... <input type="checkbox"/> You <input type="checkbox"/> Family	Being a Parent ..... <input type="checkbox"/> You <input type="checkbox"/> Family	Finances..... <input type="checkbox"/> You <input type="checkbox"/> Family
Recent Loss..... <input type="checkbox"/> You <input type="checkbox"/> Family	Disaster..... <input type="checkbox"/> You <input type="checkbox"/> Family	Other..... <input type="checkbox"/> You <input type="checkbox"/> Family

Please Use an "X" on the Scale Below to Indicate How Distressing Your Problem(s) are to You.

1	2	3	4	5	6	7	8	9	10
(Minimally Distressing)									(Extremely Distressing)

Please Describe Why You are Coming to Counseling (i.e., What are your issues, problems?): \_\_\_\_\_

Why Have You Decided to Come for Counseling Now? \_\_\_\_\_

What do You Hope to Gain or Change by Coming to Counseling? \_\_\_\_\_

How Long Do You Think Counseling Should Last? \_\_\_\_\_

## PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential / in-Patient Care You Have Received (Use back if Necessary):

Therapist: \_\_\_\_\_ Location: \_\_\_\_\_ Dates \_\_\_\_\_

Reason: \_\_\_\_\_

Therapist: \_\_\_\_\_ Location: \_\_\_\_\_ Dates \_\_\_\_\_

Reason: \_\_\_\_\_

Therapist: \_\_\_\_\_ Location: \_\_\_\_\_ Dates \_\_\_\_\_

Reason: \_\_\_\_\_

## RELIGIOUS

What Words Would You Use to Describe Yourself? \_\_\_\_\_

If God Were to Describe You, What Would He Say? \_\_\_\_\_

Complete the Following Thought: God is \_\_\_\_\_

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: \_\_\_\_\_

What is the name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader? \_\_\_\_\_

Do You Have a Personal Support System?  Yes  No If Yes, Who: \_\_\_\_\_

Are You in a Small Group?  Yes  No

Do You Regularly Attend Church?  Yes  No

## TERMS OF SERVICE

*I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24 – hour notice of intention to cancel, I will be charged the full administrative fee for service.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_