New Client Information Form

Client Information

First Name _____ Last Name _____ Middle Initial _____

DOB _____ Age _____ Gender _____ Marital Status _____

Address _____

City _____State _____ Zip Code _____ Email _____

Phone (_____) -_____ Okay to text: ☐ Yes ☐ No Okay to leave msg: ☐ Yes ☐ No

Occupation _____ Employer/School _____

Caregiver Information (If client is a minor)

Last Name _____ First Name _____

Relationship _____ Phone Number _____

Emergency Contact Person

Emergency Contact _____ Phone Number _____

Client Medical History and Treatment History

Current Therapy Providers _____ Last Visit _____

Reason for Treatment/Diagnosis _____

Medical Concerns _____

Current Doctor _____ City _____

Current Medications _____

Other Concerns _____

Symptoms (last 6 months)

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Depression
- ☐ PTSD
- ☐ Trauma
- ☐ ADHD
- ☐ Self-Harm (cutting, etc)
- ☐ Suicidal Behavior/Attempt
- ☐ Death/Loss of Friend/Family
- ☐ Divorce/Break Up
- ☐ Nightmares/Flashbacks
- ☐ Loneliness
- ☐ Alcohol Issues
- ☐ Drug Addiction
- ☐ Eating Concerns
- ☐ Sleep Concerns
- ☐ School/Work Issues
- ☐ Recent Move/Changes
- ☐ Domestic Violence
- ☐ Abuse
- ☐ Sexual Abuse/Assault
- ☐ Anger Issues
- ☐ Shame/Guilt
- ☐ Self-Control Issues
- ☐ Unmotivated
- ☐ Unable to Focus
- ☐ Recent Arrest/Legal Issues

Consent for Treatment and Evaluation

Regarding services at Oaks Family Counseling, I understand that:

- My participation in any/all services is voluntary and that my consent and/or participation may be withdrawn at my discretion at any time.
- My confidentiality will be protected and personal information will not be released without my written permission.
- Counseling and behavioral health treatment is not an exact science and active and appropriate participation is necessary for best results. No specific treatment recommendations and/or outcomes can be promised or guaranteed.
- Oaks Family Counseling does not provide emergency services and I should contact a crisis line, 911, mental health facility and/or hospital in an emergency situation.
- Services will be provided within the scope of my specific provider's licensure and training. I will be informed in the event that my mental health needs are beyond the scope and practice of my provider's qualifications.
- There are legal limitations on confidentiality that must be observed by all mental health professionals. Oaks Family Counseling has a duty to protect the client and/or others who might be in harm's way in situations associated with suicidal and/or homicidal ideation. This may include helping a client attain emergency mental health services, calling 911 and/or contacting law enforcement

Signature

I, as the client, or the parent/legal guardian of the client named above, agree with the conditions above and grant Oaks Family Counseling permission to assess, evaluate and/or treat the client named above.

Signature of Client _____ Date _____

Signature of Parent/Guardian (if minor) _____ Date _____