ADULT - New Client Information

HOPE WILSON COUNSELING
Hope Wilson, PCC, LICDC
(PLEASE PRINT)

Name _____ **Date of Birth** _____
Address_____**City**_____**Zip**_____
Home phone_____**Cell**_____**Work**_____
Email_____
Employer_____ **Position:** _____
Address_____ **SS#**_____
Referred by _____**Relationship** _____
With whom do you live? (Names/ages/relationship) _____

_____

_____

Patient status: Single_____**Married**_____ **Partnered**_____ **Widowed**_____**Other**_____
Patient relationship to insured: Self_____ **Spouse**_____ **Child**_____ **Other**_____

Medical information:

Your Doctor's name/address/phone_____
Your Psychiatrist's name/address/phone_____
Significant medical conditions/disabilities_____
Current medications, dose, purpose _____

_____

Prescribing Doctor _____
Emergency contact_____
Contact relationship_____
Contact address/phone_____

What problems or difficulties bring you here? _____

_____

_____

_____

_____

Briefly describe how these problems affect your functioning_____

_____

Previous counseling, psychotherapy, or under a care of a psychiatrist? If yes, please name with whom, approximately when and length of treatment? _____

_____

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What would you like from psychotherapy? _____

_____

History of thoughts or attempts, of suicide? _____

Do you feel suicidal at this time? _____

_____

Past hospitalizations? _____

History or issues with alcohol and other drugs, cutting/self injuring behaviors, eating issues, restricting, purging, binging? No _____ Yes _____

_____

_____

_____

Family history of mental illness and/or addictions? _____

_____

_____

_____

I understand that payment is due at the time of services and agree to this contract of payment for services rendered. I understand I need to give 24 hours notice or I will be charged for the time that was reserved for me.

Signature _____ Date _____