JACKIE MOORE counseling

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214.566.3698

New Client Form

Please fill in the information below and bring it with you to your first session.
Information provided on this form is protected as confidential information.

PERSONAL INFORMATION

Name:	**Date:**
Parent/Legal Guardian (if under 18):	
Address:	
Cell #	May we leave a message? ☐ Yes ☐ No
Work/Home #:	May we leave a message? ☐ Yes ☐ No
Email:	May we leave a message? ☐ Yes ☐ No

NOTE: Email correspondence is not considered to be a confidential medium of communication.

DOB: **Age:** **Gender:**

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never Married ☐ Separated ☐ Domestic Partnership

Referred by (if any):

HISTORY

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes (previous therapist/practitioner): _____

Are you currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list:

_____

_____

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list and provide dates:

_____

_____

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GENERAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems:

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks and/or phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? (Please circle one)

Never Daily Weekly Monthly Infrequently

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

11. On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your romantic relationship?

1 2 3 4 5 6 7 8 9 10

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12. What significant life changes or stressful events have you experienced recently?

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	No / Yes	
Anxiety	No / Yes	
Depression	No / Yes	
Domestic Violence	No / Yes	
Eating Disorders	No / Yes	
Obesity	No / Yes	
Obsessive Compulsive Behavior	No / Yes	
Schizophrenia	No / Yes	
Suicide Attempts	No / Yes	

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

_____

2. Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

3. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief? _____

_____

4. What do you consider to be some of your strengths and weaknesses?

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____