Ceci Addams, MS
Licensed Marriage and Family Therapist (# MFC 45251)
dba 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_____Insurance ****** _____

****** 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_____

_____

_____