Center for Mindfulness and Psychotherapy
Stacie Smith, MA, LPC
404-606-1638

NEW CLIENT INFORMATION FORM

Name: _____

Date of Birth: _____ Age: _____

Address: _____

City: _____ ZIP: _____

Email address:_____ Home Phone: _____

Work Phone: _____ Cell phone:_____

Is it ok to leave a message? _____

Years of School Completed: _____

Employer_____ Occupation: _____

Who referred you to me? _____ May I thank that person? _____

May I contact your physician and/or psychiatrist to coordinate care? _____

Primary Care Physician: _____

Primary Care Physician Phone: _____

Psychiatrist: _____ Phone:_____

Emergency contact: _____ Relationship: _____

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Phone numbers:_____

This form is for information gathering only. Your answers will be kept confidential. You will not be judged or diagnosed by your answers, nor expected to maintain the status quo. Feel free to add any other information you think might be useful.

What, if any, previous therapy or psychological treatment have you experienced? Please include the year.

Please describe briefly what brings you to therapy at this time.

What are your hopes about therapy?

What are your fears about therapy?

How would you describe your circle of friends?

Are you currently in a primary relationship? If so, for how long? Briefly describe the qualities of this relationship at this time.

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Who lives in your household? Are you happy with this arrangement?

Please describe the strategies you most often use for coping with stress.

Do you have a history of alcohol/substance abuse? Describe your present usage.

Do you have a history of sexual abuse? Please describe briefly.

Any history of alcoholism, sexual or physical abuse, and/or mental illness in your family?

Have you ever felt or acted suicidal? Please explain.

Please list any significant (to you) accidents, surgeries, hospitalizations with date/year.

Please describe briefly your spiritual practices/beliefs, if any.

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How is your physical health?

What prescription medications, supplements, herbs and homeopathics do you currently use and how often do you take them?

Have you ever been prescribed psychiatric medication (for example, for depression or anxiety, etc)?

Please list any healthcare providers you are currently working with.

How do you feel about how you eat?

What is your daily caffeine intake?

What kind of exercise do you get and how often?

What do you do for fun?

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Please indicate any of the following problems or symptoms you are or have recently been experiencing:

__Abuse
__Appearance Concerns
__Apathy
__Appetite Concerns
__Alcohol Abuse
__Anxiety
__Assertiveness Concerns
__Bereavement/ Grief
__Career Concerns
__Communication Problems
__Concentration Problems
__Discrimination
__Domestic Violence
__Fatigue
__Harassment
__Insomnia
__Lack of Support System
__Loneliness
__Medical Problems
__Partner/Spouse Concerns
__Relationship Issues
__School Problems
__Sexual Orientation Questions
__Spirituality/Religious Concerns
__Suicidal Thoughts
__Thoughts of Hurting Others
__Withdrawal from Others
__Impulse Control Problems
__Low Self-Esteem
__Stress
__Tearfulness
__Anger
__Aggression
__Disability
__Distractability
__Depression
__Disorganization
__Family of Origin Issues
__Hallucinations
__Hopelessness
__Hopelessness
__Indecision
__Lack of Energy
__Legal Problems
__Marital Problems
__Parenting Concerns
__Racing Thoughts
__Sadness
__Self Injury
__Sleep Changes
__Substance Abuse
__Tension
__Weight Loss or Gain
__Worrying Excessively
__Eating Disorders/Concerns
__Financial Problems
__Helplessness
__Impulsiveness
__Irritibility
__Sexual Problem
__Motivation Difficulties
__Unable to Break Bad Habit

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