Vancouver Counseling Group, LLC
New Client Information Form

Date: _____

How did you find out about us? ☐ Phone Book ☐ Website ☐ Psychology Today ☐ Other _____

Please complete the 2 columns below for yourself or for your child if he/she is coming in for services.

Information Needed	Client (Self or Child)	Spouse/Partner/Parents
Name		
Address (City, State, ZIP)		
Phone: Home Work Cell	Msg. OK? Y N Msg. OK? Y N Msg. OK? Y N	Msg. OK? Y N Msg. OK? Y N Msg. OK? Y N
DOB/Age		
Place of birth		
Social Security #		
Occupation Employed by How long? Annual income		
Education		
Marital status/length		
Previous marriages (#)		

Why are you requesting services at this time? _____

_____

_____

_____

How long has this been bothering you? _____

Names and ages of children (or siblings if no children) in order of birth:

Name	Date of Birth	Age	Sex	Where do they live?

Health History:
Please describe your current health: (circle your answer below)
Physical: Excellent Good Fair Poor Mental / Emotional: Excellent Good Fair Poor

Date of last physical exam: _____ by (Physician): _____
Physician's address: _____
Clinic Name Street Address City/State/Zip

Please describe any physical health problems you (or your child) have: _____

_____

_____

Please describe any relevant mental or emotional problems you (or other members of your family) have now or have had in the past. _____

_____

_____

Please note any relevant medical or psychiatric hospitalizations: _____

_____

Do you (or your child) have a history of being abused physically or emotionally? If so, Please describe the circumstances.

_____
_____
_____

What prescription medications are you currently taking? Please list medication and dosage:

_____ _____ _____
_____ _____ _____

What non-prescription medications do you regularly take? Please list medication and dosage:

_____ _____ _____

Have you participated in any type of outpatient counseling in the past? If so, when, with whom, and for what concern?

_____

Do you drink alcoholic beverages? Yes _____ No _____
If yes, please list the kind of beverage(s) and the number of drinks you've consumed in the past week:
Kinds: _____ Number of drinks: _____
Was this a typical week? Yes ____ ____ No

Do you use any other recreational drugs/substances? Yes ____ No ____
If yes, please list the kind of drug(s) and the number of times used in the past week:
Kinds: _____ Times used: _____
Was this a typical week? Yes ____ No_ ___

Have you had any major life changes/events in the last year? Please describe: _____

_____
_____

Is there anything else that you believe is important for your therapist to know about as you begin treatment? Please describe:

_____
_____

Circle any of the following that are a concern to you:

nervous	fearful	finances	headaches	loneliness	nightmares
friends	anger	numbing out	divorce	eating problems	shyness
heart racing	on guard	relationships	concentration	impulsivity	running away
distracted	shame	self-doubt	self-esteem	sadness	self-control
work	school	withdrawn	stomach pain	hearing voices	arguments
drug use	marriage	hopelessness	sexual problems	physical abuse	suicidal
guilt	children	alcohol use	spirituality	parents	sexual abuse
memory	tension	legal problems	inferiority	people	my thoughts

This Client Information form has been completed by: _____

* If you are planning to bring your child for counseling services, please also download and complete the "Child and Adolescent Intake Form" and bring it with you for the first appointment.

** Please be sure to bring your medical insurance card with you to your appointment and present it to the receptionist or counselor when you check in. They will need it to make a photocopy for our records and confirm your coverage.