Joshua M. Noblitt
CREATIVE APPROACHES TO HEALING

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NEW CLIENT RECORD
(Confidential)

Date_____

Name_____ Date of Birth _____ Age _____

Address_____
#Street City County State Zip

Home Phone_____ Office _____ Cell _____

Which number do you prefer I call and can I leave a message? _____

Email address:_____OK to contact you via email? Y / N

If you have children, please list their names and ages_____

_____

Highest Level of Education Completed _____

Occupation _____

Employer _____

Employer's Address _____

Spouse or Partner's Name _____

Emergency Contact Name and Number_____

Your relationship with this person_____

Are you currently taking any medication? _____ If so, please indicate name of drug and reason for taking it _____
_____
_____
_____
_____

Presenting Problem: What is bringing you here today? (onset, duration, intensity, precipitating event)

_____
_____
_____
_____

Circle any of the following that pertain to you:

Alcohol Use	Fears	Paranoia
Anger	Finances	Personal Growth
Anxiety/stress	Health Problems	Physical Abuse
Attention/ADHD	HIV/AIDS	School Problems
Career/Work	Legal Matters	Self-Harm/Cutting
Communication	Loneliness	Separation/Divorce
Concentration	Loss/Grief	Sexual Abuse
Depression	Mania	Sexual Concerns
Drug Use	Marriage	Sexuality
Eating/Food	Overly Emotional	Sleep Problems
Energy	Pain	Spiritual Issues
Family/Friends	Panic Attacks	Suicidal Thoughts

Are you at risk of hurting yourself or someone else? _____

What would you like to see change? _____ _____
_____

What could prevent or block this change? _____
_____

If you have a gynecologist, urologist, internist or family doctor, please give their names and phone numbers_____
_____
_____

When did you last see a doctor? _____ Explain _____
_____

How did you get referred to me?_____

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Have you had previous counseling or psychotherapy? _____

Dates Where

_____
_____
_____

Have you had any past psychiatric hospitalizations (describe and list dates)?

_____
_____

Did you find past treatment helpful? Yes / No What was helpful/not helpful?

_____

Have you taken any psychiatric medications in the past? Yes / No List:

_____
_____

Are you willing to consider taking medication for your current problems? Yes / No

Are you currently on leave from work or seeking disability? Yes / No

Substance Abuse History

Have you ever been treated for compulsive or addictive behavior? (food, gambling, alcohol, drugs, sex, etc.): Yes / No
Are you currently attending any support groups? Yes / No
In the past 30 days what substances have you used?

Tobacco	Heroin	PCP
Alcohol	Cocaine/Crack	Ecstasy
Marijuana	Amphetamines	Special K
Sleeping Pills	Methamphetamines	Ritalin
Pain Killers	Methadone	Molly
Tranquilizers	LSD	Other:_____

Have you experienced any withdrawal symptoms?
Circle all that apply: headaches nausea vomiting tremors seeing things hearing things
Have you ever had a DUI: Yes / No

Legal Issues
Are you currently involved in any legal issues? Yes / No
Are you on parole or probation? Yes / No
Do you have any DFACS involvement? Yes / No

Family and Relationships

Please list anyone who lives with you, their age, and their relationship to you:

_____
_____
_____
_____

Does anyone in your immediate family have substance abuse, behavioral, or psychiatric problems?

_____
_____

Is your family supportive of you seeking treatment? Yes / No
Do you/have you suffered domestic violence? Yes / No
Do you have a history with sexual, physical, or emotional abuse? Yes / No
If so, which:

_____

Do you have any sexual orientation or gender issues or concerns? Yes / No

Do you have any spiritual or religious affiliations? Yes / No
Describe your spiritual/religious affiliation:

_____
_____

What are your hobbies?

_____
_____

Describe your support system:

_____
_____
_____

Describe any other information about you that you would like for me to know:

_____

_____ _____
Client Signature Date