Acct: _____

Rev: 08/19

Adult Client Information

Name: _____ Age: _____ Birthdate: _____ SSN: _____

Address: _____

Employer: _____ Occupation/Job Title: _____

Work Address: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Person Responsible for Payment (if different): _____

Birthdate: _____ SSN: _____ Phone: □ Home or □ Cell _____

Address: _____

Phone for Appointment Reminders: _____ *24-hour notice is required to avoid a possible cancellation fee.*

Emergency Contact: _____ Relationship: _____

Phone: □ Home or □ Cell _____ Work Phone: _____

How did you hear about New Beginnings Counseling Center (NBCC)? _____

Insurance Information

We require copies of ALL insurance cards pertaining to the client in order to file insurance claims.

Primary Insurance: _____ Insurance ID: _____

Subscriber Name: _____ Relationship to Client: _____

Subscriber's Address: _____

SSN: _____ Birthdate: _____ Phone: _____

Secondary Insurance: _____ Insurance ID: _____

Subscriber Name: _____ Relationship to Client: _____

Subscriber's Address: _____

SSN: _____ Birthdate: _____ Phone: _____

Consent to Receive Services

Your signature below indicates the following:

- A copy of the **NBCC Provider-Client Service Agreement** and the **NBCC Notice of Privacy Practices** has been made available to you.
- You consent to accept these policies as a condition of receiving mental health services.
- You consent to receive appointment reminders from NBCC.
- You consent to contact of the person you identified in an emergency.
- Any questions you have regarding this information have been addressed.
- You acknowledge your right to ask questions about these policies at any time.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative and Description of Personal Representative's Authority (if applicable)

Personal and Family Information

Name: _____

Acct: _____

Rev: 08/19

What brings you to counseling today? _____

_____

What are your goals for counseling? _____

_____

History of Mental Health Services: Have you received mental health services in the past? ☐ **Yes** ☐ **No**
If so, when? _____ ☐ Counseling ☐ Assessment ☐ Psychiatric Care ☐ Hospitalization

Briefly describe your experience (including clinician, diagnoses and outcome): _____

_____

Have you previously taken medications for mental health? ☐ **Yes** ☐ **No** If so, when? _____

If yes, please list medications and treatment outcome: _____

_____

Legal Involvement: Do you have any current or expected legal involvement (including divorce and custody proceedings)? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

Are you currently under an order of protection? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

Marital Status: ☐ Single ☐ Married (how long? _____) ☐ Cohabitating ☐ Separated
☐ Divorced (what year? _____) ☐ Widowed ☐ Other: _____

On a scale of 1-10, how do you rate your overall satisfaction with your marriage? _____ ☐ N/A

Are your parents divorced? ☐ **Yes** ☐ **No** If so, how old were you? _____

Regarding Your Spouse (if applicable): Has your spouse been married previously? ☐ **Yes** ☐ **No**

Are your spouse's parents divorced? ☐ **Yes** ☐ **No** If so, how old was your spouse? _____

Spouse's Name: _____ Occupation: _____

Household Information: Please provide the requested info for those currently living in your home:

Name	Age	Relationship to Self

Name: _____

Acct: _____

Rev: 08/19

Psychological Concerns (check all that apply)

Social and Occupational Concerns (Check all that apply)

Intimate Relationships
- ☐ Unfaithful Spouse/Infidelity
- ☐ Pregnancy before Marriage
- ☐ Fertility Issues
- ☐ Work Interference
- ☐ Conflict/Control Issues
- ☐ Sexual Issues
- ☐ Separation/Divorce
- ☐ Post-Divorce Issues
- ☐ Jealousy
- ☐ Other: _____

Sexuality
- ☐ Identity Concerns
- ☐ Changed Desire
- ☐ Misconduct
- ☐ Impotence
- ☐ Fearful/Inhibited
- ☐ Addiction/Excess
- ☐ Other: _____

Family
- ☐ Blended Family
- ☐ Custody Issues
- ☐ Conflict with In-Laws
- ☐ Domestic Violence
- ☐ Death
- ☐ Conflict/Fight
- ☐ Separation
- ☐ Illness
- ☐ Issues with Children
- ☐ Housing Issues
- ☐ Elderly Parents
- ☐ Other: _____

Finances
- ☐ Debt
- ☐ Bankruptcy
- ☐ Bad Checks
- ☐ IRS Problems
- ☐ Other: _____

Education/Occupation
- ☐ Lack of Career Direction
- ☐ Frequent Job Changes
- ☐ Poor Performance
- ☐ Dissatisfaction
- ☐ Harassment/Discrimination
- ☐ Lack of Education/Training
- ☐ Potential Job Loss
- ☐ Other: _____

Leisure
- ☐ No Free Time
- ☐ No Outside Interests
- ☐ Boredom
- ☐ Lack of Enjoyment
- ☐ No Friends
- ☐ No Social Outlets
- ☐ Other: _____

Name: _____

Acct: _____

Rev: 08/19

Physical Health Concerns (Check all that apply)

Changes In:
- ☐ Sleep Habits
- ☐ Appearance/Hygiene
- ☐ Energy Level
- ☐ Weight
- ☐ Other: _____

Cardiac Health
- ☐ Shortness of Breath
- ☐ Heart Racing
- ☐ Rapid Breathing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Arrhythmia
- ☐ Mitral Valve Prolapse
- ☐ Other: _____

Digestive Health
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Other: _____

Neurological Health
- ☐ Attention/Focus Issues
- ☐ Memory Problems
- ☐ Headaches/Migraines
- ☐ Vision Problems
- ☐ Seizures
- ☐ Head Injury
- ☐ Confusion
- ☐ History of Concussion
- ☐ Speech Problems
- ☐ Balance/Coordination Issues
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Blackouts
- ☐ Tremors
- ☐ Other: _____

Lung Health
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Other: _____

Endocrine Health
- ☐ Diabetes
- ☐ Thyroid Issues
- ☐ Hormone-Related Issues
- ☐ Other: _____

Muscle/Bone Health
- ☐ Chronic Pain
- ☐ Back Issues
- ☐ Weakness
- ☐ Other: _____

Gynocological Health
- ☐ Menstrual Difficulties
- ☐ PMS Symptoms
- ☐ Miscarriage
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Other: _____

Other
- ☐ Skin Rash/Issues

Additional Health Information (Including treatment dates)

☐ Cancer History: _____ ☐ Surgeries: _____

☐ Allergies: _____ ☐ Other: _____

How would you describe your overall health? ☐ Excellent ☐ Average ☐ Poor

Current Prescriptions, Over-the-Counter Medications, Herbs, and Supplements

Name	Dose/Frequency	Condition Treated	Date Prescribed

Alcohol, Tobacco, Marijuana and Other Drugs

Substance	Amount/Frequency	Currently Using (Y/N)	Comments