VITALMIND SOLUTIONS

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NEW CLIENT INFORMATION

Name _____ Date of Birth ____/____/_____

Preferred Phone _____ □CellPh □HmPh □WkPh □Other _____

Email _____ Preferred Communication □Cell □HmPh □WkPh □Email

Okay to leave a message on my: □ Home □Cell □Work number □Other

Residential Address _____ City _____ Zip _____

May I send mail to this address? □Yes □No

Email _____May I use email to confirm appointments? □Yes □No

Employer _____ Type of Work _____

Relationship Status (Circle those that apply):

Single/Married/Partnership/Poly Relationships/Divorced/Separated/Widowed/Other

Emergency Contact _____Relationship_____Phone_____

What prompted you to seek therapy?

_____
_____
_____
_____
_____

Who is impacted by the issue?

_____
_____
_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____
_____
_____
_____

Have you had any prior counseling or psychiatric treatment? □No □Yes
If yes:

When? _____
Where?_____

Reason for seeking previous counseling?_____
Length of previous counseling?_____

Check one: Therapy was □ helpful □ not helpful. Please explain:
_____
_____

MEDICAL/ PHYSICAL HEALTH

Name, address and phone number of your primary care physician**:**
_____
_____
_____
_____

Date of your last physical exam
_____

Have you been under a physician's care for any reason in the last five years? If yes, please explain:

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____

_____, _____(Initial and Date Here)

____Eating disorder ____Obsessive thoughts _____

Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse? □ Yes □ No

Have you ever felt like you should cut down on alcohol or other drug use? □ Yes □ No

Has a friend or relative ever discussed concerns about your drug use? □ Yes □ No

Is there a history of problem with alcohol or drug use in your family? □ Yes □ No

Have you received help for drug or alcohol dependency? □ No □ Yes If yes:

When? _____
Where?_____

Check one: Treatment was □ helpful □ not helpful. Please explain:
_____
_____

MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____