# NEW CLIENT INFORMATION FORM

*Please provide the following information and answer the questions below.*

**Client Information**

**Date**: _____

**Name**: _____

**Home Phone**: _____ **Cell Phone**: _____

Is it okay to leave messages at these numbers? □ Yes □ No
If no, please list which number it is okay to leave a message_____

**E-MailAddress**:
_____

**Home Address**:_____
Street Address

_____
City State Zip

**Occupation**: _____

**Age _____** **Date of Birth**: _____

**Marital Status**:
□ Never Married □ Married □ Domestic Partnership □ Divorced □ Widowed

**Emergency Contact Information:**

Name: _____

Relationship: _____

Phone: _____

**Education**:
_____

## Health

How would you rate your overall physical health?
□ Excellent □ Great □ Good □ Fair □ Poor

Do you have any sleep problems? □ Yes □ No

If yes, please describe:_____

Are you dealing with any past or current addictions? □ Yes □ No

If yes, please describe: _____

_____

Have you had any issues with Depression, Anxiety, or ADD/ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)? □ Yes □ No

If yes, please describe:_____

Are you currently seeing a therapist? □ Yes □ No

If yes, please describe what issues your addressing in therapy:

_____

_____

Are you currently taking any medications? □ Yes □ No

If yes, please list:

_____

_____

Do you exercise regularly? □ Yes □ No

If yes, please describe what you do and how often: