Bridges Counseling Center
Shelly Aldrich, LMFT (916)797-3344 ext. 107
9253 Sierra College Blvd., Suite 100* Roseville, CA 95661

NEW CLIENT INFORMATION

Client Name ________________________ **Today's Date** ____________________________
(To be completed by the Parent/Guardian if client is younger than 18 years)

Date of Birth ______________________ **Age** ____________ **Social Security #** ______________________

Address ______________________ **Email address** ______________________

City ______________________ **State**______________________ **Zip Code**______________________

Phone Number(s) Home ______________________ **Cell** ______________________ **Other**______________________

May we call you: at Home? ____ yes ____ no on Cell? _____yes ______ no on Other? _____yes ______no

Relationship Status: Single ________ **Married – Date** ________ **Separated – Date** ________ **Divorced – Date** ________
(Circle one) Widowed - Date ________ **Living together – Date** ________

People living in home/ages ______________________
____
____
____

Children not in home/ages ______________________
____
____
____

Occupation ______________________ **Employer** ______________________

School/Grade:______________________

Person to be contacted in case of an emergency
Name ______________________ Relationship ______________________
Home phone number ______________________ Work phone number ______________________

Presenting Problem(s):
Please describe your reasons for seeking counseling (include date the problem started):
____
____
____

Goals for Therapy:______________________
____

How did you hear about us?
____

New Client Information

Client Name ______________________________________**Social Security #** ______________________________

Medical History:
Please list any prescription medications you currently use:

NAME DOSAGE FREQUENCY

____

____

Primary Care Physician ______________________________ **Phone Number** ______________________________

Please list any medical conditions (past or current) that the therapist should be aware of:

____

____

When did you last have a physical examination? ____

Who did you see? ______________________________ ______________________________
Name Phone Number

Psychiatric History:
Have you ever received psychological or psychiatric treatment of any kind before? [ ] Yes [ ] No
If you answered yes to the above question, please answer the following:
What type of care did you receive? [ ] Inpatient (hospital) [ ] Outpatient [ ] Both
When were you in treatment? ____
Where were you in treatment? ____
How long were you in treatment? ____
Who was your therapist or doctor? ____
Did your doctor prescribe medicine at this time? [ ] Yes [ ] No [ ] not applicable
If Yes, what was prescribed (include dosages if known)? ______________________________

____

Family History:
Describe any significant emotional, medical or chemical dependency conditions of your parents and/or other family members:

____

____

Substance Use History:
Have you ever abused drugs or alcohol? [ ] Yes [ ] No If yes, please describe:

Substances	Amount	Frequency	When? (First use; Last use)

Have you ever received substance abuse treatment or any kind before? [ ] Yes [ ] No
Do you have a history of blackouts, seizures, or withdrawal symptoms? [ ] Yes [ ] No
Please describe anything else you would like your clinician to know:

____

Habits:	**Amount Currently Using**	**Most Ever Used**
Coffee (cups/day)		
Cigarettes (packs/day)		
Alcohol		

New Client Information

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PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No effect	Little effect	Some effect	Much effect	Significant effect	N/A
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A

If your eating habits are affected, describe how: ______________________________

____

Sleeping Habits	1	2	3	4	5	N/A

If your sleeping habits are affected, describe how: ______________________________

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Sexual functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your temper	1	2	3	4	5	N/A