



GIFT

COUNSELING CENTER
FOR WELLNESS, LLC

New Client Information

Date: _____

Referral Source: _____

Client Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity/Nation/Tribe: _____

Parent/Guardian: _____

Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity/Nation/Tribe: _____

Parent/Guardian: _____

Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity/Nation/Tribe: _____

Current Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Phone: (Cell) _____ (Home) _____ Okay to leave a message? Yes / No

Email: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____



Family Relationships

Children or other Significant Relationships:

Name	Age/DOB	Sex	Relationship	Additional Information

Presenting Concern:

Current Symptoms:



Previous Mental Health Treatment:

Goals/Changes:

Vocational/Employment:

Education:

Legal/Childwelfare:



Family/Child History:

Alcohol/Substance Abuse

Mental Illness/Problems:

Depression

Anxiety

Bipolar Disorder

ADHD

PTSD

Learning Disorders

Schizophrenia

Alzheimer's

Suicide Attempt/Completion

Other

Notes:

Prenatal/Developmental History:

Medical History:



Significant trauma's/losses/life events:

History of Abuse/Neglect/Exploitation:

Sleep Hygiene:

Nutrition:

Exercise:

Social Support:

Discipline:

Spirituality or Religion:

Interests/Hobbies:



Additional Information:

Client Signature

Date