Rich Greete, M.A., M.Div.
Licensed Mental Health Counselor MH 9297
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Youth - Confidential New Client Information Form

GENERAL INFORMATION

Date: _____Referred by: _____

Full Name: _____

Nick Names: _____ Name You Prefer: _____

Social Security Number:_____ Date of Birth: _____ Age: _____

Ethnicity: White / Black / Hispanic / Asian / Other: _____ Sex: Male / Female

Street Address: _____ Suite Apartment # _____

City: _____ State: _____ Zip Code: _____
May we send mail here: ___ Yes / ___ No

Mailing Address or Post Office Box: ___ Same as above

Street Address: _____ Suite Apartment # _____

City: _____ State: _____ Zip Code: _____
May we send mail here: ___ Yes / ___ No

Home Phone: _____ Call you here? ___ Yes ___ No Message here? ___ Yes ___ No

Cell Phone: _____ Call you here? ___ Yes ___ No Message here? ___ Yes ___ No

Email Address: _____ May We Send Email Here? ___ Yes ___ No

Employer:_____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Completed: ___ 9 ___ 10 ___ 11 ___ 12 ___ GED College: ___1 ___ 2 ___3 ___4 Other: _____

Are You Currently In School? ___ Yes ___ No If Yes, What Level: _____ Degree Pursuing: _____

Do You Regularly Attend A Place Of Worship? ___ Yes ___ No If Yes, Where? _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

RELATIONAL INFORMATION

Relationship Status: ___In a Relationship ___Would Like to be in a Relationship ___ Not Even Looking

Are You Content with Your Current Status: ___ Yes ___ No If No, Briefly Explain: _____

If You are in a Relationship How Long: _____ Briefly Describe your Parnter:_____

With Whom Do you Currently Live *(check all that apply)* ___ Mother ___ Father ___ Step-Mother ___ Step-Father

___ Sibling(s) ___Boyfriend ___ Girlfriend ___ Roommate ___ Pet ___ Other: _____

Have You Ever Placed a Child for Adoption? ___ Yes ___ No If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion? ___ Yes ___ No If Yes, when: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effect or have Effected You Positively or Negatively (use back if necessary):

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling)	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Date of Last Physical: _____

List Any Medical Conditions, Illnesses, Treatments, or Surgeries: _____

_____

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ___ Improves ___ Prevents ___ Controls _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: ___ Yes ___ No

Your Height: _____ Your Weight: _____

How Has Your Weight Changed in the Last 2 - 3 Months: _____

Are You Presently Experiencing Any Suicidal Thoughts? ___ Yes ___ No

Have You Ever Experienced them in the Past? ___ Yes ___ No

Have You Ever Attempted Suicide? ___ Yes ___ No If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide? ___ Yes ___ No If Yes, When and Who:

_____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms / Sensations that Apply to You Presently, or in the Recent Past:

Headaches…….. __ Past __ Present	Dizziness……__ Past __ Present	Stomach Trouble…__ Past __ Present
Visual Trouble……__ Past __ Present	Sleep Trouble…….__ Past __ Present	Trouble Relaxing…__Past __ Present
Weakness…….. __ Past __ Present	Tension…….. __ Past __ Present	Rapid Heart Rate….__Past __ Present
Difficulty Breathing... __ Past __ Present	Intestinal Trouble... __ Past __ Present	Hearing Noises……__ Past __ Present
Change in Appetite….__ Past __ Present	Tiredness…… __ Past __ Present	Pain……..__ Past __ Present
Hearing Voices…….. __ Past __ Present	Seeing Things…… __ Past __ Present	Other……__ Past __ Present

PRESENT ISSUES

Please Check Any of the Following Physiological Symptoms / Sensations that You or Your Family Are Presently Experienceing:

Stress……__ You __ Family	Nervousness……..__ You __ Family	Anxiety……__ You __ Family
Panic……..__ You __ Family	Unhappiness……..__ You __ Family	Depression……__ You __ Family
Guilt…….. __ You __ Family	Apathy…….. __ You __ Family	Terminal Illness……__ You __ Family
Recent Death…… __ You __ Family	Grief…… __ You __ Family	Hopelessness…… __ You __ Family
Inferiority……..__ You __ Family	Defective Feelings.__ You __ Family	Loneliness…… __ You __ Family
Shyness…….. __ You __ Family	Fears…….. __ You __ Family	Friends…….. __ You __ Family
Marriage…… __ You __ Family	Communication…. __ You __ Family	Physical Abuse…….. __ You __ Family
Emotional Abuse…… __ You __ Family	Verbal Abuse……. __ You __ Family	Sexual Abuse…… __ You __ Family
Temper…… __ You __ Family	Anger…….. __ You __ Family	Aggressiveness…….. __ You __ Family
Bad Dreams…… __ You __ Family	Concentration……. __ You __ Family	Racing Thoughts…… __ You __ Family
Unwanted Thoughts… __ You __ Family	Memory…….. __ You __ Family	Loss of Control…….. __ You __ Family
Impulsive Behavior… __ You __ Family	Self-Control…… __ You __ Family	Compulsivity…… __ You __ Family
Sexual Problems…… __ You __ Family	Pregnancy……... __ You __ Family	Abortion…… __ You __ Family
Legal Matters…….. __ You __ Family	Trauma…… __ You __ Family	Eating Problems……. __ You __ Family
Drug Use…… __ You __ Family	Alcohol Use…… __ You __ Family	Trouble with Job…… __ You __ Family
Career Choices…… __ You __ Family	Ambition…… __ You __ Family	Making Decisions…. __ You __ Family
Children…….. __ You __ Family	Being a Parent …... __ You __ Family	Finances…… __ You __ Family
Recent Loss…… __ You __ Family	Disaster…… __ You __ Family	Other…… __ You __ Family

Please Use an "X" on the Scale Below to Indicate How Distressing Your Problem(s) are to You.

_____

0 1 2 3 4 5 6 7 8 9 10

(Not at all Distressing) (Extremely Distressing)

Please Describe Why You are Coming to Counseling (i.e., What are your issues, problems?): _____

_____

Why Have You Decided to Come for Counseling Now? _____

_____

What do You Hope to Gain or Change by Coming to Counseling? _____

_____

How Long Do You Think Counseling Should Last? _____

Have You Ever Had a Seizure? Yes / No Are You Pregnant? Yes / No

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential / in-Patient Care You Have Received (Use back if Necessary):

Therapist: _____ Location: _____ Dates _____

Reason: _____

RELIGIOUS

What Words Would You Use to Describe Yourself? _____

If God Were to Describe You, What Would He Say? _____

Complete the Following Thought: God is _____

Briefly Describe the Religious Environment of Your Home as You Were Growing Up: _____

_____

What is the name of Your Pastor, Priest, Rabbi, or Other Spiritual Leader? _____

Do You Have a Personal Support System? ___ Yes ___ No If Yes, Who: _____

Are You in a Small Group? ___ Yes ___ No

Do You Regularly Attend Church? ___ Yes ___ No

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24 – hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____

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CONSENT TO TREAT MINOR

Name of Minor to be Treated: _____
(Child's Full Name)

I agree to avail the above-named minor child to the professional services of: Richard A Greete, M.A., M. Div. who is a Licensed Mental Health Counselor MH 9297, and consent accordingly to the minor child being seen in individual psychotherapy.

Name of Parent or Legal Guardian: _____
(Please Print Full Name)

Signed: _____ Date: _____

Witnessed: _____ Date: _____