New Client Information

If you are coming as a couple, please each of you fill out this form.
Date _____

Client's Last Name_____ First Name_____

Spouse/Partner's Last Name_____ First Name _____

Home Address_____

City_____ State_____

Zip Code_____

How did you hear about Covington & Hafkin?_____

* For the following contact information please provide phone and email addresses that are **ONLY** accessed by you. Please initial next to the phone and email that you provide consent/permission for your therapist to contact you at these numbers. Please star preferred contact information.

Home Telephone (___)_____-_____ Work Telephone (___)_____-_____

Cell Telephone (___)_____-_____ E-Mail _____

Birth Date _____ Age_____ Gender: Male Female

Highest Education: High School Some college College degree Master's Doctorate Other

Are you affiliated with a religion or spiritual group? YES NO If yes, specify_____

Relationship Status: Single Married Partnered Separated Divorced Widowed

If partner, years together: _____ If separated/divorced/widow, for how long:_____

Do you have children? YES NO If yes, names/ages: _____

_____

Employer Name:_____

Have you been in therapy before? Yes No When?_____

Who was your previous therapist?_____ How long were you in therapy?_____

How helpful was it and what was your experience like? _____

_____

Have you ever been evaluated by a psychiatrist for medication? Yes No

Psychiatrist's Name? _____ When? _____

What was the reason?_____

Medications Prescribed: _____, _____, _____

Have you ever been hospitalized for mental health issues? Yes No

Where:_____ When?_____

For how long?_____

The reason (s) I/we am/are seeking counseling services at this time: _____

_____

PRIMARY COMPLAINTS AT THIS TIME

Please check **all** that apply:

____Depression	____Fertility Issues	____Marital Issues
____Anxiety	____Sexual Dysfunction	____Panic Attacks
____Post-Traumatic Stress	____Relationship Problems	____Medical Crisis
____Grief/Loss	____Adjustment to New Situation	____Pregnancy/Postpartum issues
____Suicidal/Homicidal Thoughts	____Occupational Difficulties	____Other:_____

Is there anything else important about you that you'd like to add? _____

_____