Fern Snogren LCSW, MA, CHT • ***Mindfulness-Based, Somatic Psychotherapy***

NEW CLIENT INFORMATION FORM

Name (Last, First, Middle) ______________________________

Street Address ____________ City ____________ State ____ Zip ______

Mailing Address ____________ City ____________ State ____ Zip ______

Telephone Home ____________ Work ____________ Mobile ____________

Other ____________ Where can I leave messages? ____________

Birth Date ________ Age ____ Childhood Nicknames ____________

Gender ____________ Sexual Orientation ____________

Relationship Status ☐ Married ☐ Never Married ☐ Widowed ☐ Single
☐ Divorced ☐ Separated ☐ Living Together As Partners

If married or with a significant other, what is the duration of the relationship? ____________

How would you characterize this relationship? ____________

____

____

____

Are there children living at home? ☐ Yes ☐ No

Names and ages of children ____________ Age ____ ____________ Age ____

____________ Age ____ ____________ Age ____

Spouse / Partner's Name ______________________________ Age ____

Please list your past significant relationships, your approximate age ranges during them, and how long they lasted:

____

____

____

List your siblings, their ages, and a brief description of your relationship with each:

____

____

____

Please list any significant losses you have experienced (who, when, how they died):

____

____

____

Employer / School ____________________ Occupation ______________________________

Education / Training (highest level attained) ________________________________

Previous Vocations ____

Military Service ☐ Yes ☐ No Dates ________________ Did you serve in combat? ☐ Yes ☐ No

Have you had previous therapy? ☐ Yes ☐ No Spiritual or pastoral counseling? ☐ Yes ☐ No

When? ____

____

With whom? ____

____

Are you presently seeing a therapist? ☐ Yes ☐ No If yes, whom? ____________________

List past inpatient, intensive outpatient mental health, or drug/alcohol treatment you have received:

____

List mental health diagnoses you have received ______________________________

List past or present legal involvement ______________________________________

List mind-altering substances you have used in the past ________________________

List any mind-altering substances you use currently, including approximate amounts and frequencies ____

____

If you or others have concerns about your use of substances, please describe: ______________

____

Have you suffered abuse or other trauma? ☐ Yes ☐ No

Your Physician's Name ______________________ Date of last medical exam __________

Are you currently on medication? ☐ Yes ☐ No

If so, which medication(s)? ____

Prescribed by ____________________ Major surgeries in the past five years? ☐ Yes ☐ No

For which condition(s)? ______________________________

Other health conditions ______________________________

What is your current physical condition? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

What is your current emotional condition? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Which of the following describe or relate to the concerns that bring you here?

☐ Aging Issues
☐ Anger
☐ Alcohol / Drugs
☐ Anxiety
☐ Eating / Food
☐ Faith
☐ Fear
☐ Finances
☐ Frequent Crying
☐ Gender Identity
☐ Grief

☐ Guilt
☐ Hopelessness
☐ Identity
☐ Legal Issues
☐ Life Transition
☐ Loneliness
☐ Meaning
☐ Mid-Life Issues
☐ Physical Health
☐ Poor Appetite
☐ Religious Doubts

☐ Self-Doubt
☐ Self-Esteem
☐ Self-Loathing
☐ Sexual Concerns
☐ Sleep Disturbances
☐ Suicidal Feelings
☐ Vocation/Career Issues
☐ Weight Loss

Relationship with:

☐ Partner
☐ Parents
☐ Children
☐ Others

Abuse issues:

☐ Sexual
☐ Physical
☐ Emotional
☐ Verbal

State in your own words the concerns that bring you to therapy ______________________________

____

____

____

____

How will you know when your current concerns are resolved? ______________________________

____

____

____

____

Emergency Contact ____________ Phone ____________ Relationship ____________

How did you hear about me? ______________________________