Guiding Hope Counseling Center
217 Lovern Street
Hazard, Ky 41701
Ph: 606-439-0900
F: 606-487-0085

*New Client Information*

Please note: information provided on this form is protected as confidential information.

*Personal Information*

**Client Name**:_____
**Parent/Legal Guardian Name (if under 18)**:_____
**Mailing/Physical Address:**_____
**Home Phone**: ___ _____May we leave a message? □ Yes □ No
**Cell/Work/Other Phone**: _____ May we leave a message? □ Yes □No
**Email**: _____May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
**Client DOB: _____ Age: _____ Gender: _____**
**Marital Status:**
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed
Referred By (if any): _____

*History*

Have you previously received any type of mental health services (psychotherapy, psychiatric services,
etc.)?
□ No □ Yes, previous therapist/practitioner: _____
Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:
_____
_____
_____
Have you ever been prescribed psychiatric medication? □ Yes □ No

If yes, please list and provide dates:

_____

_____

*General and Mental Health Information*

1. How would you rate your current physical health? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise?

_____

4. Please list any difficulties you experience with your appetite or eating problems:

_____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how
long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this?

_____

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe:

_____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently? _____

_____
_____

*Family Mental Health History*

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

*Please List Family Member*

Alcohol/Substance Abuse_____
Anxiety_____
Depression_____
Domestic Violence_____
Eating Disorders_____
Obesity_____
Obsessive Compulsive Behavior_____
Schizophrenia_____
Suicide Attempts_____

*Additional Information*

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation?
_____
_____
Do you enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:
_____
_____

3. What do you consider to be some of your strengths?
_____
_____
_____
_____

4. What do you consider to be some of your weaknesses?
_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

_____

_____