



Guiding Hope Counseling Center  
217 Lovern Street  
Hazard, Ky 41701  
Ph: 606-439-0900  
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### *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:

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Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

If yes, please list and provide dates:

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*General and Mental Health Information*

1. How would you rate your current physical health?

☐ Poor    ☐ Unsatisfactory    ☐ Satisfactory    ☐ Good    ☐ Very good

Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits?

☐ Poor    ☐ Unsatisfactory    ☐ Satisfactory    ☐ Good    ☐ Very good

Please list any specific sleep problems you are currently experiencing:

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

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

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5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ No ☐ Yes

If yes, for approximately how long?

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6. Are you currently experiencing anxiety, panics attacks or have any phobias? ☐ No ☐ Yes

If yes, when did you begin experiencing this?

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7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes

If yes, please describe:

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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?

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

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

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### *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?

\_\_\_\_\_

\_\_\_\_\_

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?

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