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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, duration of present marriage _____ Are there children living at home? Yes No

Names and ages of children _____ Age _____ Age _____

_____ Age _____ Age _____

Spouse / Partner's Name _____ Age _____

Previous Marriages (Date / How Ended) _____

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, who? _____

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 _____

Do you use any mind-altering substances currently? Yes No

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?

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Aging Issues | <input type="checkbox"/> Guilt | <input type="checkbox"/> Self-Doubt | Relationship with: |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Partner |
| <input type="checkbox"/> Alcohol / Drugs | <input type="checkbox"/> Identity | <input type="checkbox"/> Self-Loathing | <input type="checkbox"/> Parents |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Legal Issues | <input type="checkbox"/> Sexual Concerns | <input type="checkbox"/> Children |
| <input type="checkbox"/> Eating / Food | <input type="checkbox"/> Life Transition | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Others |
| <input type="checkbox"/> Faith | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Suicidal Feelings | |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Meaning | <input type="checkbox"/> Vocation/Career Issues | Abuse issues: |
| <input type="checkbox"/> Finances | <input type="checkbox"/> Mid-Life Issues | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Sexual |
| <input type="checkbox"/> Frequent Crying | <input type="checkbox"/> Physical Health | | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Gender Identity | <input type="checkbox"/> Poor Appetite | | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Religious Doubts | | <input type="checkbox"/> 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? _____