Nina Serman Counseling, LLC

Nina Serman, LPC-MHSP
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NEW CLIENT INFORMATION

Identifying Information:

Name: ____ Date: _________________

Address: ____

City: _______________________________ State: __________ Zip Code ________________

Daytime telephone: ________________ Evening: ________________ Cell: ______________

Fax: ____________________________ Email: _____________________________________

Date of Birth: _________________________ Age: _____ Marital Status: _________________

Emergency Contacts: (Please list two emergency contacts):

Name: __________________________________ Relationship to Client: __________________

Daytime telephone: ________________ Evening: ________________ Cell: ________________

Name: __________________________________ Relationship to Client: __________________

Daytime telephone: ________________ Evening: ________________ Cell: ________________

Responsible Party: (If someone other than client is responsible, please complete the following)

Name: __________________________________ Relationship to Client: __________________

Address: ____

City: _______________________________ State: __________ Zip Code _________________

Daytime telephone: ________________ Evening: ________________ Cell: ________________

Fax: ____________________________ Email: ______________________________________

PRIMARY CONCERNS

1. Please describe the primary concern that brought you to our office:

____
____
____
____
____

2. What led to your decision to seek help at this time?

____
____
____
____
____

3. How severe is the concern for you at this time?

☐Mild ☐Moderate ☐Severe ☐Very Severe ☐Extremely Severe

4. When did the problem/concern begin? What do you think triggered it?

____
____
____
____
____

5. What have you done to cope with or manage the problem/concern?

____
____
____
____
____

6. Is there anything else, now or in the past, which has been very stressful for you?

____
____
____
____
____

7. How would you describe your mood during the past week:

☐ Depressed ☐ Irritable ☐ Anxious/nervous ☐ Good ☐ Other:__________________

8. Please describe your strengths: ____

____
____
____

MEDICAL HISTORY

1. Do you receive regular medical care from a physician or clinic? ☐ Yes ☐ No; If yes,

Physician's Name: ____ Phone: __________________
Address: ____

Physician's Name: ____ Phone: __________________
Address: ____

2. When was your last complete physical examination? ___________________________________

3. Please list your prescription medications:

____
____
____

4. Please list any vitamins, herbal remedies, or over-the-counter medications that you take:

____
____

5. Have you ever had any of the following illness, injuries, or medical events?

	Yes	No		Yes	No
High blood pressure			Migraine headaches		
Diabetes			Other headaches		
Cancer*			Colitis		
Fibromyalgia			Irritable bowel syndrome		
Thyroid disease			Tuberculosis		
Stroke*			Head injury*		
Asthma			COPD/emphysema		
Seizures*			Sleep apnea		
Hormone problems*			Premenstrual syndrome		
Chronic pain*			Heart disease		
Multiple sclerosis			Peptic/stomach ulcers		
Hospitalizations*:			Surgeries*:		
Chemical exposure*:			Other*:		
Hepatitis:			Other*:		

*Please describe: ____
____
____
____
____
____
____

6. Do any of the following symptoms apply to you currently?:

	Yes	No		Yes	No
Dizziness			Muscle spasms		
Heart skipping beats			Tension		
Headaches			Tremors		
Stomach problems			Chest pain/tightness		
Rapid heart beat			Fatigue		
Blackouts			Sweating		
Fainting			Bladder problems		
Bowel problems			Shortness of breath		
Skin problems			Sexual problems		
Cold all the time			Overweight		
Appetite changes			Lumps anywhere		
Hot spells/flashes			Sleep problems		
Weight changes			Coughing or wheezing		
Memory problems			Morning headaches		
Snoring			Menstrual problems		
Pain problems			Hearing problems		
Visual problems			Speech problems		
Falling down			Unusual or excessive thirst		
Legs jerking			Daytime sleepiness		

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

1. Have you ever been treated for mental health issues? □ Yes □ No; If yes,
a. When? ____
b. By whom? ____

2. Please list any/all mood medication(s) you are taking now. Circle the number of days you took each medication during the past week:
Medication: _________________________ 1 2 3 4 5 6 7
Medication: _________________________ 1 2 3 4 5 6 7
Medication: _________________________ 1 2 3 4 5 6 7
Medication: _________________________ 1 2 3 4 5 6 7

3. Please list any mood medication(s) you have taken in the past but are not taking now:
Medication: _________________________ Reason stopped: __________________________________
Medication: _________________________ Reason stopped: __________________________________
Medication: _________________________ Reason stopped: __________________________________
Medication: _________________________ Reason stopped: __________________________________

4. What type(s) of psychotherapy have you received in the past? □ None
□ Individual □ Group □Family □Other: ______________________________________

5. If you have been hospitalized for mental health reasons, please list: ☐ Does not apply
a. When?: ____
b. Where?: ____
c. For how long? ____
d. For what reason(s): ____

6. Please check "Yes" or "No" for the following questions:

	Yes	No
a. Have you ever thought about suicide?		
b. Have you recently thought about suicide?		
c. Have you ever attempted suicide?		
d. Has anyone in your family ever attempted suicide?		
e. Have you recently thought about physically injuring/hurting someone?		
f. Have you ever physically injured/hurt someone?		
g. Have you ever been a victim of domestic violence?		
h. Have you ever been a victim of abuse of any kind?		
i. Are you currently in an abusive relationship?		
j. Are you aware of services available to victims of abuse/domestic violence?		

SOCIAL HISTORY

1. What is your current relationship status?
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Engaged ☐ In a committed relationship

a. How long have you been married/in this relationship? ______________________________

b. How would you rate your overall satisfaction with the relationship?
☐ Very unsatisfied ☐Unsatisfied ☐Neutral ☐Satisfied ☐Very Satisfied

c. Please list any relationship issues or concerns that you would like to address in therapy:

____

____

d. How many times have you been married? ______________________________

2. How many children do you have? ____________________ ; please indicate:

Age	Gender	Quality of Relationship
_____	_____	______________________________
_____	_____	______________________________
_____	_____	______________________________
_____	_____	______________________________

3. Who else lives in your home? ______________________________

4. What is your current occupational status?
☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

a. If employed,
• What is your occupation? ____
• Where do you work? ______________________________ How long? ____________
• How satisfied are you with your current employment?
☐ Very unsatisfied ☐Unsatisfied ☐Neutral ☐Satisfied ☐Very Satisfied

b. If disabled,
•For what reason? _____________________________________How long? __________
•What type of work did you previously do? ______________________________________

c. If retired,
•What type of work did you previously do? ______________________________________
•When did you retire? ____

d. If unemployed,
• For how long? _______________ For what reason? ____________________________

e. Are you in the process of filing a disability claim? ☐ Yes ☐ No
•If yes, is your visit to this office in any way related to this claim? ☐ Yes ☐ No

5. What is the highest grade/level of schooling you completed? ________________________
a. What were your typical grades? ____
b. What was your best subject? ____
c. What subject was most difficult? ____
d. Were you ever diagnosed with a learning disability? _____________________________
e. If you dropped out of school at any level, please indicate reason: ____________________
f. Please describe any behavioral problems during school (skipping class, fighting, suspensions, drug/alcohol use, etc.) ____

6. Are you currently experiencing any legal problems? ☐ Yes ☐ No
• Have you experienced legal problems in the past? ☐ Yes ☐ No; If yes, please explain:
____
•Is your visit to this office in any way related to a pending or future legal issue?
☐ Yes ☐ No; If yes, please explain: ____

7. Did you serve in the military? ☐ Yes ☐ No; If yes,
• What branch? _______________ Dates of service? ____________________________
• Did you engage in combat? ____
• Rank at discharge? ___________ Reason for leaving military? ______________________

8. Do you have continuing involvement in religious or spiritual activities? ☐ Yes ☐ No
a. What is your religious preference? ____
b. Are you satisfied with the spiritual dimension of your life? ☐ Yes ☐ No

9. Please complete the following table describing your social habits:

Social Habits	**Now**	**Past***	**Type**	**Quantity**	**How often?**
Alcohol					
Street drugs					
Caffeine (coffee, soda, tea, chocolate, NoDoz, energy drinks)					
Tobacco					
Diet Pills					
Hobbies					
Exercise					

*If past, indicate when.

FAMILY HISTORY

1. Where were you born? City: ______________________ State: ________________
2. Where were you raised? City: ______________________ State: ________________
3. Please complete the following table describing your family relationships:

Relative	**Current Age**	**Health** Status	**If deceased, age and cause**	**Quality of relationship in childhood**	**Quality now (if living)**
Mother					
Father					
Stepparents					
Grandparents					
Brothers					
Sisters					
Other:					
Other:					

4. Did you suffer any abuse or trauma as a child? ☐ Yes ☐ No

____

5. Please describe any known problems or complications with your birth: ☐None known

____

6. Please describe any significant childhood illnesses or injuries: ☐ None known

____

7. Did any of your family members have mental health problems? ☐ Yes ☐ No; if yes,
a. Who? ____
b. What type of problem(s)? ____

8. Did any of your family members abuse alcohol or drugs? ☐ Yes ☐ No; if yes,
a. Who? ____
b. What type? ____

OTHER IMPORTANT INFORMATION

Please describe or list anything else that is important for us to know:

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THERAPY GOALS CHECKLIST

In order to address the issues that are most important to you, please circle all items listed below that reflect your current treatment goals.

1. Better managing stress
2. Better managing anger
3. Addressing grief and loss
4. Improving my sleep
5. Losing weight
6. Gaining weight
7. Improving my body image
8. Feeling better about myself
9. Addressing spiritual issues
10. Reacting less emotionally
11. Improving my relationships
12. Addressing past trauma
13. Stopping smoking
14. Taking better care of my physical health
15. Better managing my pain condition
16. Learning how to relax
17. Learning about exercises that I can do
18. Decreasing fears and worries
19. Managing thoughts of harming myself or others
20. Learning about medications to help with my mood
21. Feeling less depressed
22. Feeling less anxious or nervous
23. Better managing unwanted thoughts
24. Learning about a diagnosis
25. Maintaining my sobriety
26. Other: ____
27. Other: ____

1. Please review the items you have circled on the previous page. Which three areas do you most wish to address at this time:

First ________
Second ________
Third ________

2. How certain are you that you will be able to make changes in these areas?

□ Very uncertain
□ A little uncertain
□ Becoming more certain
□ Certain
□ Very Certain

3. How motivated are you to begin making these changes?

□ Not at all motivated to change
□ Thinking about making changes
□ Planning to change
□ I'm already making changes
□ I've successfully made the changes I want to make

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Adult Symptom Checklist

Place check all of the symptoms listed below which you have experienced and indicate whether these are occurring now or in the past. If in the past, please indicate when these symptoms last occurred.

Symptom	Now	Past
☐Feeling depressed, sad, blue	☐ Now	☐ Past ________________
☐Loss of interest in activities	☐ Now	☐ Past ________________
☐Sleep problems	☐ Now	☐ Past ________________
☐Low energy/fatigue	☐ Now	☐ Past ________________
☐Feeling irritable/angry	☐ Now	☐ Past ________________
☐Memory or concentration problems	☐ Now	☐ Past ________________
☐Withdrawing from others/isolating	☐ Now	☐ Past ________________
☐Thoughts of harming yourself	☐ Now	☐ Past ________________
☐Thoughts of harming others	☐ Now	☐ Past ________________
☐Hearing voices	☐ Now	☐ Past ________________
☐Seeing things others don’t see	☐ Now	☐ Past ________________
☐Thoughts that others are trying to hurt you	☐ Now	☐ Past ________________
☐Thoughts that you can’t get out of your head	☐ Now	☐ Past ________________
☐Feeling nervous/anxious	☐ Now	☐ Past ________________
☐Panic attacks	☐ Now	☐ Past ________________
☐Racing thoughts	☐ Now	☐ Past ________________
☐Counting, checking, arranging/rearranging	☐ Now	☐ Past ________________
☐Washing hands too much	☐ Now	☐ Past ________________
☐Too much energy	☐ Now	☐ Past ________________
☐Spending too much money	☐ Now	☐ Past ________________
☐Engaging in dangerous activities on purpose	☐ Now	☐ Past ________________
☐Forced vomiting after eating	☐ Now	☐ Past ________________
☐Poor appetite	☐ Now	☐ Past ________________
☐Overeating	☐ Now	☐ Past ________________
☐Weight gain or loss	☐ Now	☐ Past ________________
☐Exercising too much	☐ Now	☐ Past ________________
☐Restricting food	☐ Now	☐ Past ________________
☐Drinking too much alcohol	☐ Now	☐ Past ________________
☐Using street drugs	☐ Now	☐ Past ________________
☐Gambling	☐ Now	☐ Past ________________
☐Abuse	☐ Now	☐ Past ________________
☐ Domestic Violence	☐ Now	☐ Past ________________
☐Relationship problems	☐ Now	☐ Past ________________
☐Family problems	☐ Now	☐ Past ________________
☐Cutting, scratching or burning yourself	☐ Now	☐ Past ________________
☐Pulling your hair out	☐ Now	☐ Past ________________
☐Other :____________________________	☐ Now	☐ Past ________________
☐Other :____________________________	☐ Now	☐ Past ________________
☐Other :____________________________	☐ Now	☐ Past ________________