Matt Wagner, LPC, Inc.
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NEW CLIENT INFORMATION

NAME: _____ DATE: ____/____/_____

PRIMARY PHONE NUMBER: ( ) _____ Okay to text? ___ Yes ___ No

EMAIL ADDRESS: _____ Okay to email? ___ Yes ___ No

ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ GENDER IDENTIFICATION: _____

MARITAL/PARTNER STATUS (Circle):

Single Married/Committed Relationship Widowed Divorced/Separated

NAMES AND AGES OF CHILDREN [For example, *Andrew (9), Emily (7)*]

_____

HIGHEST LEVEL OF EDUCATION: _____

CURRENT PLACE OF EMPLOYMENT: _____

OCCUPATION: _____

PREVIOUS COUNSELING: ____ YES _____ NO

If 'Yes', please briefly describe when, the length of counseling and issues addressed: _____

_____

_____

What are your main reasons for seeking counseling now? _____

_____

_____

Are you currently having any suicidal thoughts? ___ Yes ___ No

Have you been hospitalized for any psychiatric/mental health purposes? ___ Yes ___ No (if "yes", please provide dates and purpose of hospitalization) _____

Do you have any substance abuse problems? ___ Yes ___ No ____ Currently sober (provide length of sobriety) _____

PHYSICAL HEALTH / MEDICAL CONCERNS

Any major illnesses and/or operations you have had?

_____

_____

Any current physical or medical concerns?

_____

_____

Name of number of current physician

_____

Okay for me to contact this person? ____ Yes ____ No

Name and number of current psychiatrist (if applicable)

_____

Okay for me to contact this person? ____ Yes ____ No

Most recent physical exam?_____

MEDICATIONS	DOSAGE	PURPOSE OF MED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY INFORMATION

PARENTAL STATUS: Married/Living Together Separated/Divorced Other

Mother's Age: _____ If deceased, how old were you when she died? _____

Father's Age: _____ If deceased, how old were you when he died? _____

If divorced, how old were you when this happened? _____

Siblings: (Name, Age, Current Living Location)

_____	_____	_____	_____
(Name)	(Gender)	(Age)	(Current Living Location)
_____	_____	_____	_____
(Name)	(Gender)	(Age)	(Current Living Location)
_____	_____	_____	_____
(Name)	(Gender)	(Age)	(Current Living Location)
_____	_____	_____	_____
(Name)	(Gender)	(Age)	(Current Living Location)

Briefly describe your relationship with your mother: _____

_____

Briefly describe your relationship with your father: _____

_____

EMERGENCY CONTACT IN CASE OF MEDICAL OR PSYCHOLOGICAL EMERGENCY (NOTE: This person would only be contacted with your consent, or upon life-threatening circumstances)

Name: _____ Relationship: _____

Address: _____

Phone number: _____ Other phone: _____

Is there any additional information you think would be important for me as your therapist to know?

_____

_____

_____

_____

Fee for a 50-minute counseling session is $125. If you would like to request a lower fee, please provide your total household income (including spouse or partner if in a shared living space), as well as number of dependents.

_____