Oaktree Counseling
Nikki Schwartz, MA, LPC, NCC
Licensed Professional Counselor

New Client Form (Adult)

Date

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can.

General Client Information

Name: First, Middle, Last Gender: ☐ M ☐ F Age: DOB:

Occupation: Handedness: ☐ R ☐ L Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Issues

Please provide a brief description of why you are seeking counseling/therapy services at this time:

Has anything happened that may have brought on/intensified the problems you are experiencing? ☐ Yes ☐ No
If yes, please explain:

- When (month/year) did you first begin to experience these problems?
- How many days, weeks, months, or years have you been experiencing these problems?
- How often do you experience these problems? (check the one that best describes your current experience).
  - ☐ Most of the day, every day
  - ☐ Some part of the day, every day
  - ☐ Most of the day on most days
  - ☐ Some part of the day on most Days
  - ☐ More than once a week
  - ☐ More than once a month
  - ☐ Other
- How much is/are the problems affecting you? ☐ Mildly ☐ Moderately ☐ Severely
- In what areas do your problems impact your life? (Check all that apply)
  - ☐ Lifestyle (the way you live your life)
  - ☐ Activities (things you normally do or would like to do)
  - ☐ Relationships (your ability to form or maintain relationships with others)
  - ☐ Eating
  - ☐ Sleeping
  - ☐ Mood
- Have you ever attempted suicide? ☐ Yes ☐ No If yes, when?
- Have you been thinking about suicide? ☐ Yes ☐ No
- Have you ever thought about harming or killing someone else? ☐ Yes ☐ No If yes, when?
- Have you been thinking about harming or killing someone else? ☐ Yes ☐ No

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Adult Problems Checklist

Instructions: Please check all that apply to you

- ☐ *Depression*
- ☐ *Low energy*
- ☐ *Low self-esteem*
- ☐ *Poor concentration*
- ☐ *Lack of interest/enjoyment in life*
- ☐ *Lack of motivation*
- ☐ *Feeling hopeless*
- ☐ *Feeling worthless*
- ☐ *Feeling guilty or shameful*
- ☐ *Sleep changes (more/less)*
- ☐ *Loneliness*
- ☐ *Bad dreams/nightmares*
- ☐ *Feeling Ignored or abandoned*
- ☐ *Appetite changes (more/less)*
- ☐ *Mood swings*
- ☐ *Thoughts of hurting self*
- ☐ *Thoughts of hurting others*
- ☐ *Isolating from others*
- ☐ *Feelings of sadness/loss*
- ☐ *Weight problems*
- ☐ *Stress*
- ☐ *Anxiety/tension/worry*
- ☐ *Panic attacks*
- ☐ *Heart racing*
- ☐ *Chest pain or heaviness*
- ☐ *Chills/hot flashes*
- ☐ *Tingling/numbness*
- ☐ *Muscle twitches*
- ☐ *Pain*
- ☐ *Fear of dying*
- ☐ *Fear of going "crazy"*
- ☐ *Nausea*
- ☐ *Fears or phobias*
- ☐ *Obsessions/compulsions*
- ☐ *Thoughts racing*
- ☐ *Disorganization*
- ☐ *Procrastination*
- ☐ *Can't hold onto an idea*
- ☐ *Anger/frustration*
- ☐ *Suspiciousness/mistrustfulness*
- ☐ *Problems trusting others*
- ☐ *Easily irritated/annoyed*
- ☐ *Aggressiveness*
- ☐ *Perfectionist behavior*
- ☐ *Lying*
- ☐ *Making/keeping friends*
- ☐ *Arguing with others*
- ☐ *Performing unusual rituals or habits*
- ☐ *Impulsiveness*
- ☐ *Excessive behaviors (Ex: spending, gambling)*
- ☐ *Delusions/hallucinations (Thinking/believing or seeing/hearing unusual things)*
- ☐ *Sexual problems*
- ☐ *Poor attention*
- ☐ *Completing tasks*
- ☐ *Staying on task*
- ☐ *Hyperactivity*
- ☐ *Difficulty sitting still*
- ☐ *Fidgeting*
- ☐ *Clumsiness*
- ☐ *Excessive talking*
- ☐ *Poor organization*
- ☐ *Poor time management*
- ☐ *Procrastination*
- ☐ *Sensory sensitivities*
- ☐ *Sensory deficits*
- ☐ *Auditory*
- ☐ *Hypersensitivity*
- ☐ *Auditory deficits*
- ☐ *Visual hypersensitivity*
- ☐ *Visual Deficits*
- ☐ *Tinnitus (ears ringing)*
- ☐ *Poor body awareness*
- ☐ *Shyness*
- ☐ *Poor social skills*
- ☐ *Lack of social support, family/friends*
- ☐ *Autism*
- ☐ *Lack of eye contact*
- ☐ *Poor social/emotional reciprocity*
- ☐ *Poor emotional awareness*
- ☐ *Poor speech articulation*
- ☐ *Echolalia*
- ☐ *Lack of social interest*
- ☐ *Lack of social awareness*
- ☐ *Motor/vocal tics*
- ☐ *Poor empathy*
- ☐ *Stuttering*
- ☐ *Difficult to soothe*
- ☐ *Easily embarrassed*
- ☐ *Emotionally reactive*
- ☐ *Self-Injurious Behavior*
- ☐ *Pulling out hair, fingernails, eyelashes, or eyebrows*
- ☐ *Picking at skin or scabs*
- ☐ *Oppositional or Defiant*
- ☐ *Stealing*
- ☐ *Strange, weird, or peculiar behavior*
- ☐ *Confusion/Can't think clearly*
- ☐ *Feeling "not real"*
- ☐ *Feeling detached from yourself*
- ☐ *Feeling "hyper"*
- ☐ *Physical illness*
- ☐ *Allergies*
- ☐ *Asthma*
- ☐ *Walking or moving*
- ☐ *Fatigue*
- ☐ *Irritable bowel syndrome*
- ☐ *Low muscle tone*
- ☐ *Muscle weakness*
- ☐ *Poor motor coordination*
- ☐ *Poor balance*
- ☐ *Heart palpitations*
- ☐ *High blood pressure*
- ☐ *Tachycardia*
- ☐ *Immune Deficiency*
- ☐ *Sugar craving/reactivity*
- ☐ *Food sensitivities*
- ☐ *Chronic pain*
- ☐ *Fibromyalgia/CFS*
- ☐ *TMJ or jaw pain*
- ☐ *Migraine headaches*
- ☐ *Tension headaches*
- ☐ *Sinus headaches*
- ☐ *Sciatica*
- ☐ *Abdominal Pain*
- ☐ *Financial problems*
- ☐ *Grief/bereavement*
- ☐ *Health problems*
- ☐ *Impact of your problems on others*
- ☐ *Losing track of time*
- ☐ *Problems with memory*
- ☐ *Unpleasant thoughts that won't go away*
- ☐ *Bothered by recurring thoughts*
- ☐ *Job/career problems or indecision*
- ☐ *Destruction of property*
- ☐ *Self-criticism*
- ☐ *Family problems*
- ☐ *Marital/relationship problems*
- ☐ *Parent/child problems*
- ☐ *Use of alcohol*
- ☐ *Use of drugs*
- ☐ *Blackouts*
- ☐ *Physical abuse*
- ☐ *Sexual abuse*
- ☐ *Partner abuse*
- ☐ *Trouble with the law*
- ☐ *Experienced/witnessed trauma*
- ☐ *Loss/death of someone close*
- ☐ *Other (please describe below)*

Other, please describe:

Current Life Experiences

I live in: ☐ Apartment ☐ House ☐ Condo/Townhouse ☐ Mobile Home ☐ Rooming House ☐ Other

I live with:

Name	Age	Relationship to me	Problems

Other significant persons in my life who do not live with me include:

Name	Age	Relationship to me	Problems/Resides where?

Problems or changes in my family or other important interpersonal relationships:

Date(s)	Persons Involved	Relationship to me	Problems or Changes

Problems or changes in occupational, educational, social, or recreational functioning:

Date(s)	Problems or Changes

My sources of satisfaction:

My sources of stress:

My leisure activities:

My current life goals:

What I hope to gain from counseling/therapy:

My typical day is as follows (attach extra sheets, if necessary)

History of Counseling or /Therapy

Are you **currently** being treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above? ☐ Yes ☐ No If yes, please provide the following information:

Date(s)	Name of Professional/Address	Treatment Type (counseling, therapy, medication, etc.)

Please provide information regarding **previous** treatment you have received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional/Address	Treatment Type/Why treatment ended

Have you ever been hospitalized for treatment of an emotional or mental disorder? ☐ Yes ☐ No
If yes, please provide the following information:

Date(s)	Name of Hospital or Facility/Address	Reason for Hospitalization

Medical History

Please complete the information below regarding **past and current** medical conditions and treatment:

Date(s)	Physician Name / Address	Condition/Treatment/Results

Please list any allergies/sensitivities/drug reactions:

Medical History Continued

Please list all **current** prescription and over the counter medication use:

Beginning (date)	**Medication/Dose/Frequency of use**	**Condition Treated**

Please list any **previous** prescription and over the counter medication use significant to your counseling/therapy:

Date(s)			**Medication/Dose/Frequency of use**	**Condition Treated**
From		To		
From		To		
From		To		
From		To		

Please list any **current or previous** use of street drugs, tobacco products, or alcohol:

Date(s)			**Type Used/Frequency of Use/Amount Typically Used**	**When ended (if applicable)**
From		To		
From		To		
From		To		

Please list any hospitalizations or surgeries:

Date(s)	**Hospital/Facility**	**Physician**	**Condition/Type Treatment/Surgery**

Medical & Neurological Checklist Neurofeedback Clients ONLY

Have you *ever* had issues, problems, or concerns with any of the following, check all that apply to you:

- ☐ *Difficulty falling asleep*
- ☐ *Staying asleep*
- ☐ *Waking up in the morning*
- ☐ *Restless sleep*
- ☐ *Sleepwalking*
- ☐ *Severe &/or freq. nightmares*
- ☐ *Other Sleep Issues*
- ☐ *Allergies*
- ☐ *Asthma*
- ☐ *Frequent Illness*
- ☐ *Fatigue*
- ☐ *Chronic Pain*
- ☐ *Skin Problems*
- ☐ *Eczema*
- ☐ *Psoriasis*
- ☐ *Hypertension*
- ☐ *Palpitations or Tachycardia*
- ☐ *Hearing problems*
- ☐ *Ringing in the ears*
- ☐ *Earaches*
- ☐ *Problems with sense of smell*
- ☐ *Vision problems*
- ☐ *Double or blurred vision*
- ☐ *Blind spots*
- ☐ *Eye pain*
- ☐ *Visual sensitivity*
- ☐ *Seeing shadows*
- ☐ *Digestive or Endocrine problems*
- ☐ *Thyroid*
  - ☐ *high* ☐ *low* ☐ *abnorm*
- ☐ *Heat or cold sensitivity*
- ☐ *Diabetes*
- ☐ *Sugar sensitivity*
- ☐ *Stomach Pain*
- ☐ *Intestinal Pain*
- ☐ *Irritable Bowel Syndrome*
- ☐ *Chronic Constipation*
- ☐ *Nausea or vomiting (unrelated to virus/flu)*
- ☐ *PMS*
- ☐ *Menopausal symptoms*
- ☐ *Headaches*
- ☐ *Migraines*
- ☐ *Fainting*
- ☐ *Seizures*
- ☐ *Poor coordination*
- ☐ *Chronic aching pain*
- ☐ *Chronic nerve pain (burning or stabbing)*
- ☐ *Chronic pain or stiffness*
- ☐ *Tremor or spasticity*
- ☐ *Physically over or under active*
- ☐ *Accident Prone*
- ☐ *Motor or vocal tics*
- ☐ *Other speech problems or impediments*
- ☐ *Low pain threshold*
- ☐ *High pain tolerance*
- ☐ *Prenatal stress or injury*
- ☐ *Premature or late birth*
- ☐ *Prenatal drug exposure*
- ☐ *Difficult birth or labor*
- ☐ *Colic*
- ☐ *Delays in motor development*
- ☐ *Sleep problems*
- ☐ *Eating problems*
- ☐ *Difficult emotional attachment to caregivers*
- ☐ *Delayed emotional development*
- ☐ *Physical injury/trauma*
- ☐ *Head injury w/o loss of consciousness*
- ☐ *Head injury w/ loss of consciousness*
- ☐ *Accidents*
- ☐ *High Fever*
- ☐ *Central Nervous System Infect ion*
- ☐ *Drug overdose*
- ☐ *Poisoning*
- ☐ *Anoxia (lack of oxygen)*
- ☐ *Stroke*
- ☐ *Psychological trauma*
- ☐ *Abuse or neglect*
- ☐ *Death in family*
- ☐ *Illness in family*
- ☐ *Excessive or extreme family stress*
- ☐ *Excessive school or job stress*
- ☐ *Other (please describe):*

Family History for Neurofeedback Clients Only

Has anyone in your family, **(parents, siblings, maternal/paternal, aunts, uncles, grandparents)** *ever* experienced any of the following:

- ☐ *Asthma*
- ☐ *Autoimmune Disorders*
- ☐ *Type I Diabetes*
- ☐ *Rheumatoid Arthritis (RA)*
- ☐ *Lupus*
- ☐ *MS*
- ☐ *Other Autoimmune Disorders*
- ☐ *Thyroid Disorder*
- ☐ *Migraines*
- ☐ *Sleep problems*
- ☐ *Depression*
- ☐ *Bipolar or Manic Depression*
- ☐ *Anxiety*
- ☐ *Phobias*
- ☐ *Panic Attacks*
- ☐ *Motor or Vocal Tics*
- ☐ *Seizuress*
- ☐ *Eating Disorders*
- ☐ *Obesity*
- ☐ *Addictions*
- ☐ *Obsessive Compulsive Symptoms*
- ☐ *Speech Problems*
- ☐ *Attention Problems*
- ☐ *Hyperactivity*
- ☐ *Learning Problems*
- ☐ *Conduct Problems or Criminal Behavior*
- ☐ *Autistic Spectrum Disorders*
- ☐ *Schizophrenia*

If you answered yes to any of the above, please list the issue and the relationship to the family member

Issue	**Family Member(s)**

Family of Origin

Please list the members of your family of origin in the order that they were born. Include current ages.

Example: Maternal grandmother (deceased), Mother (age 50), father (age 49), sister Anne (age 29), brother Larry (age 27), me (age 24) lived in the childhood home.

Please describe the background or status of your family of origin for the following categories:

Ethnic

Religious:

Social:

Financial:

Briefly describe any of the following that apply to your family of origin:

Crisis or other significant events:

Any emotional, psychological, or physical illness:

(Examples: cancer, diabetes, heart disease, depression, alcoholism, drug abuse or addiction, family violence, depression, suicide)

Parenting styles of your mother, father, and other caretakers? Who did what and how?

Communication styles in your family of origin? Who did most of the talking, teaching, and connecting?

Your childhood/adolescent relationship with your:

Mother:

Father:

Stepparent:

Siblings:

Other significant family members:

Your current relationship with your:

Mother:

Father:

Stepparent:

Siblings:

Other significant family members:

Spouse, or significant other:

In-laws:

Your Children/Stepchildren/Grandchildren:

Your employer/coworkers:

Your friends:

Other significant persons:

Developmental History

Briefly describe your (1) **physical**, (2) **psychological**, (3) **emotional**, (4) **intellectual**, (5) **social**, (6) **spiritual**, and (6) **academic development**, and (7) **any significant experiences** affecting you during the following stages of your life (attach extra sheets, if needed):

Prenatal development and infancy (conception up to age 2):

Early Childhood (age 2 through age 5):

Middle and Late childhood (age 6 through age 11):

Adolescence (age 12 through age 17):

Adulthood (age 18 and up):

Client/Patient Signature: _____ *Date:* _____