Jessica Saperstone, LCSW

New Client Information Form

Today's Date: _______________

Name: ____ Date of Birth: _____________________________

Address: ____

Phone(s): ________________________________ Email Address: __________________________________

Preferred contact method: phone_____ text______ email _____

Employer or School (if student): ____

Referred By: ____

Permission to notify professional referral source of follow-through? Yes ________No______________

Emergency contact: Name ___________________________ Relationship___________________________

Contact information____

Name of local physician/health care provider: ____

Significant health concerns or symptoms: ____

____

Has a physician ever prescribed medication for anxiety or depression? No___ Yes ___ When ________

What prescription medications are you currently taking? _______________________________________

What supplements, if any, do you use? ____

Have you ever seen a counselor or psychotherapist? Yes___ No____

Have you been hospitalized for mental health or chemical dependency? No ___ Yes ___ When ______

Are you or others concerned about your use of alcohol and/or other substances? No _____ Yes _____

Have you ever tried to stop using either? No ____ Yes ____ How long ago__________________________

Please rate your overall sleep and nutrition patterns? Sleep ________________ Nutrition ____________

Which of the following have ever been part of your self-care practice? (Check all that apply)

Regular Exercise __ *Yoga* __ *Mindfulness*__ *Other Meditation Practice* __ *Biofeedback* __

Massage __ *Acupuncture* __ *Healthy Eating* __ *Reiki or other Energy Treatment* ___

*Tai Chi*__ *Qigong*___ *Other*____