Omaha Psychotherapy

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New Client Information Form

Please complete the following information. Information provided here is confidential.

Date: _____

Name: _____
(First) (Middle Initial) (Last)

Name of parent or guardian (if you are under age 18):

_____
(First) (Middle Initial) (Last)

Gender: ☐ Male ☐ Female

Relationship: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

Date of Birth: _____ Age: _____

Social Security Number: _____

Address:_____
(Street and Number)

_____
(City) (State) (Zip code)

Home Phone: _____ Cell Phone: _____

E-mail address: _____

What's the best way to reach you? _____

Please specify if it is NOT okay to contact you via any of the above means: _____

Current Employment Status: ☐ Employed Full-time ☐ Employed Part-time ☐ Self-employed ☐ Not currently working outside the home ☐ Disabled ☐ Retired

Occupation: _____

Employer: _____

Address: _____

Insured Information

[If same as client, write "client" on Last Name line and skip to insurance questions on this page.]

Last Name:_____ First:_____ Middle Initial: ___

Mailing Address (if different from above):

Street Address: _____ City: _____State: ___ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security Number: _____ Relationship: _____

Primary Insurance: _____ I do ___/do not ___ want to file claims with this company.

Insurance ID: _____ Insurance Group: _____

Secondary Insurance: _____I do ___/do not ___ want to file claims with this company.

Insurance ID: _____ Insurance Group: _____

[Please present your insurance card(s) to therapist at beginning of session for photocopying.]

Referral Information

How did you find us? _____

Referred by: _____ Reason: _____

Primary reason for seeking services: _____

Household Information

Please list the names and ages of members of your household along with their relationship:

_____

_____

_____

Medical Information

Please list any medical problems: _____

_____

Please list any medications you are currently taking: _____

_____

Who is your primary physician? _____

How would you rate your current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your current sleeping? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Cultural Information

Do you consider yourself to be religious or spiritual? _____

What religion (if any) do you identify with? _____

Are there any cultural issues or concerns we should be aware of?
_____

Strengths and Goals

What do you consider to be your strengths? _____

_____

_____

What are areas of your life you'd like to improve? _____

_____

_____

What are some of your goals for therapy? _____

_____

_____

Anything else you'd like us to know? _____

_____

_____

_____

Checklist of Concerns

Please mark all of the items below that are areas of concern for you. You may also add other concerns.

☐ Abuse (physical, sexual, emotional, neglect)
☐ Aggression, violence
☐ Alcohol use
☐ Anger, hostility, irritability, rage
☐ Anxiety, worry
☐ Career concerns
☐ Childhood issues from your past
☐ Children, child management, parenting
☐ Codependence
☐ Concentration problems
☐ Confusion
☐ Compulsions
☐ Communication difficulties
☐ Custody of children
☐ Decision making difficulties
☐ Delusions (false ideas)
☐ Dependence
☐ Depression, sadness
☐ Divorce, separation
☐ Drug or alcohol use concerns
☐ Eating issues
☐ Emptiness, lack of self-worth
☐ Failure
☐ Fatigue
☐ Fears, phobias
☐ Financial concerns, debt, low income
☐ Friendship concerns
☐ Gambling
☐ Grief, mourning
☐ Guilt
☐ Headaches
☐ Health and physical concerns
☐ Hormonal concerns
☐ Inferiority feelings
☐ Infertility
☐ Interpersonal conflicts
☐ Impulsiveness, loss of control
☐ Irresponsibility
☐ Legal issues
☐ Loneliness
☐ Marital conflict, infidelity, affairs
☐ Memory problems
☐ Mood swings
☐ Motivation concerns
☐ Nervousness, tension
☐ Obsessions, compulsions
☐ Oversensitivity to rejection
☐ Panic or anxiety attacks
☐ Perfectionism
☐ Pessimism
☐ Procrastination
☐ Relationship concerns
☐ School problems
☐ Self-centeredness
☐ Self-esteem
☐ Self-neglect, poor self-care
☐ Sexual issues
☐ Shyness
☐ Sleep issues
☐ Smoking and tobacco use concerns
☐ Stress
☐ Suspiciousness
☐ Suicidal thoughts
☐ Temper problems
☐ Weight concerns
☐ Work concerns

Other concerns: _____ _____
_____ _____
_____ _____