N-Courage Counseling, LLC
875 Market Street
Lemoyne, PA 17043
(717)897-0484

New Client Information Form

Please type or print the following information.

Name: _______________________________________

Date of Birth: ___/___/______ Age: ______ Gender: ____________________________________

Address: ____

(Street) (City) (State) (Zip code)

Phone numbers: ____

(cell) (other)

Email address: __________________________________

How do you prefer to be contacted? _______________

Emergency Contact Name: _______________________ Emergency Contact Number: ________________

Marital Status: _________________________________

Occupation: _________________________________ Years employed at this job: _____________________

Highest level of education attained: ______________Religious orientation: _________________________

Please list all people living with you, relationship to you, and ages:

Please list the names of your family of origin, begin with oldest and include self in the birth order (please note if any are divorced or deceased).

Have any members of your family been diagnosed with a psychological disorder such as Depression, Anxiety, Bi-polar, ADHD, Schizophrenia, or Substance Use disorder? (please list) ___________________
____

List any current health concerns and/ or medications you are taking: ____________________________
____
____

Primary Care Physician: ____

(Name) (Address) (Phone)

Have you utilized psychological services in the past? Yes / No

If yes, list years and issues addressed: ____
____
____

If yes, what was beneficial and what wasn't: ____
____

Have you ever been hospitalized for psychological purposes? If so, please list approximate dates and reason for admission: ____
____

In the past 6 months have you had thoughts of killing yourself? __________________________________

In the past 6 months have you had thoughts of killing someone else? ____________________________

Have you considered or attempted suicide in the past? ____
____

Do you engage in self-harming behaviors such as cutting, burning or punching yourself? _____________

Frequency of alcohol use: ___________________ Frequency of other substance use: _______________

Describe the main concerns in your life right now: ____
____
____
____
____
____
____

If you experience any of the following, please list frequency:

Sleep issues:____

N-Courage Counseling, LLC
875 Market Street
Lemoyne, PA 17043
(717)897-0484

Headaches: ____

Panic symptoms: ____

Stomachache/GI distress: ____

Shortness of breath: ____

Nightmares: ____

The following is a list of symptoms which are common in various psychological disorders, please highlight or circle all symptoms which you have experienced in the past month:

Depressed mood	Excessive anxiety or worry	Eating until uncomfortably full	Unusually high self-esteem
Loss of interest or pleasure	Difficulty managing worry	Eating alone due to embarrassment	Increased rate of speech
Weight loss or gain	Restlessness	Feeling out of control	Little need for sleep
Slowed thoughts and movements	Irritability	Feelings of guilt after overeating	Increase in risky activities
Fatigue	Specific fears	Purging or restricting	Pacing, hand wringing
Daily feelings of worthlessness or guilt	Difficulty falling or staying asleep	Unwanted, upsetting memories	More distracted than usual
Difficulty concentrating	Avoid social situations	Strong startle response	Relational conflict
Recurrent thoughts of death	Sweating, nausea, diarrhea	Nightmares or flashbacks	Decreased functioning at work

Please include any additional information which will be helpful to our work together: ________________
____
____
____
____
____
____
____