

New Hope Personal Growth Center

Client Identification Information

Date ____/____/____

Referred by:					
Client Information					
Name (Last)	(First)	(MI)	Age	Birthdate (mm/dd/yyyy)	Sex
				____/____/____	M <input type="checkbox"/> F <input type="checkbox"/>
Address		(City)	(State)	(Zip)	
Social Security Number		Home Phone		Cell Phone	
____-____-____		()		()	
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> (Please indicate # of times)					
Religious Affiliation:			Name of Church:		
Employment: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Disability <input type="checkbox"/> Retired <input type="checkbox"/> Military Service <input type="checkbox"/>					
Education (highest grade completed)				Veteran Yes <input type="checkbox"/> No <input type="checkbox"/> [date(s) of service]	
Employer			Your Work Phone		
Occupation			How Long Employed?		

State briefly reason for coming in...

Continue to next page –

If client is a minor or dependent adult, also complete supplement 1 for each parent/responsible adult – see page 5

Family History				
Family Members	Age	History of Mental Health Issues? Explain	Living? (Yes/No)	Occupation
Spouse's Name				
Mother's Name				
Father's Name				
Stepmother's Name				
Stepfather's Name				
Other significant person responsible for raising you				
Other significant person responsible for raising you				
Names, ages and gender for children of person completing form as well as any other people living in client's household				
Name	Relationship to Client	Gender: M/F	Age	
Are there any deceased children?				
Number of brothers and sisters (living? deceased?)				
Other persons living in current household and their relationship				

Continue to next page –

Client Health Information

Physician's name	Date of last physical exam
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Do you have any current physical health concerns/problems? Please describe.	Are your health problems being treated?
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Surgical History (type of surgery & your age at the time of surgery)	Date of Surgery

Please list current medications (including vitamins & herbs)	Dosage

Previous psychiatric or chemical dependency hospitalization? Yes No
 If yes, where? When?

Please briefly explain reason for hospitalization.

Continue to next page –

Have you ever seen any of the following for help with a problem?

Specialist	Reason for services	Dates of service
Psychiatrist		
Psychologist		
Mental Health Counselor		
Social Worker		
Minister		
Chemical Dependency Counselor		
DHS Social Worker		
Probation Officer or Juvenile Court Officer		
Other		

Substance Use History

 Denies Substance abuse history

Substance Name	Age Started	Current Amount	Frequency of Use	Last Used
Alcohol				
Marijuana				
Methamphetamine				
Over-the-counter drug abuse				
Prescription drug abuse				
other				
other				

Continue to next page –

Suppliment 1 – parent/responsible adult information

Parent/Responsible-Adult Name (Last)	(First)	(MI)	Relationship to Client?
Address	(City)	(State)	(Zip)
Social Security Number _____-_____-_____	Home Phone ()	Cell Phone ()	
Birthdate (mm/dd/yyyy) ____/____/____	Sex	M ___ F ___	
Marital Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Partnered ___ (Indicate # of times)			
Employment: Full time ___ Part time ___ Student ___ Disability ___ Retired ___ Military Serv. ___			
Education (highest grade completed)	Veteran Yes ___ No ___ [date(s) of service]		
Employer	Your Work Phone		
Occupation	How Long Employed?		

Please list all other people living in household, relationship to client, gender and age

Name	Relationship to Client	Gender: M/F	Age