New Day Christian Counseling, LLC
Dianne L. Taylor, M.A., LPC
12160 Abrams Road, Ste. 502
Dallas, TX 75243
214-681-3373

Confidential Client Information

Welcome to New Day Christian Counseling. To help me get to know you better, please answer all questions as completely as possible. Information given is strictly confidential and is beneficial for providing the best possible service to you as a client. Feel free to ask for assistance if needed. Your responses will be discussed in your initial interview.

BACKGROUND INFORMATION

Name: _____ Today's Date: _____

Home Address: _____ (receive mail here? Yes/No)

City: _____ State: _____ Zip Code: _____

Home Phone: _____ (May call: Yes/No) (May leave a message: Yes/No)

Work Phone: _____ (May call: Yes/No) (May leave a message: Yes/No)

Cell Phone: _____ (May call: Yes/No) (May leave a message: Yes/No)

Email Address: _____ (May email: Yes/No)

Would you like emails about upcoming events or other information from New Day? Yes/No

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Never married ❑ Engaged ❑ Separated ❑ Divorced ❑ Widowed

Number of Marriages & Length of Each: _____

_____

Are you currently involved in a custody dispute? ❑ Yes ❑ No

Are you currently involved in a legal dispute? ❑ Yes ❑ No

Religious Affiliation as a Child: _____ As an Adult: _____

Occupation: _____ Education: _____

Name of Person(s) to contact in case of an emergency:

1. _____ _____ Phone: _____
2. _____ Phone: _____

Briefly describe your reason for seeking counseling: _____

_____

How did you hear about New Day Christian Counseling? _____

Family of Origin (parents/guardians, siblings)

Name	Age	Relationship

Immediate Family Members (spouse, children)

Name	Age	Relationship

Does anyone in your immediate family or family of origin suffer from alcoholism, an eating disorder, depression or anything that might be considered a mental disorder? ❑ Yes ❑ No If yes, please explain: _____

_____

MEDICAL INFORMATION

Primary Care Physician: Name: _____

Address: _____

Phone: _____

How would you rate your current physical health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches): ❑ Yes ❑ No

If yes, please explain: _____

_____

List medications you are currently taking:

Medication	Dosage and times per day

Current illnesses or disabilities: _____

_____

_____

Please list any learning disabilities: _____

_____

Please list hospitalizations for medical reasons:

Date/Hospital and City	Reason

Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____

MENTAL HEALTH INFORMATION

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? ❑ Yes ❑ No

If so, do you feel it would be helpful for me to speak with that person? ❑ Yes ❑ No

Previous Mental Health Professional (name or agency): _____

Phone: _____ Dates of Service: from ____/____ to ____/____

Have you ever been hospitalized for mental health concerns? ❑ Yes ❑ No If yes, please explain briefly

(include hospital, doctor's name and dates): _____

_____

_____

Has any family member ever: ❑ Attempted Suicide ❑ Committed Suicide ❑ Attempted Homicide ❑

Committed Homicide If yes, briefly explain: _____

_____

Have you ever:

❑ Had suicidal thoughts ❑ Attempted Suicide ❑ Attempted Homicide ❑ Committed Homicide

If yes, briefly explain: _____

_____

_____

History of physical/sexual abuse? If yes, briefly explain: _____

_____

_____

CURRENT CONCERNS

❑ Abuse (physical, emotional, sexual)
❑ Abuse of non-prescription drugs
❑ Adjustment to life changes (move, job)
❑ Anger
❑Anxiety (nervous, clingy, fearful, worried)
❑ Behavior problems
❑ Being a parent
❑ Binging/Vomiting/Laxative use
❑ Blackouts or temporary loss of memory
❑ Bowel disturbances
❑ Career choices
❑ Children having problems
❑ Compulsive behaviors
❑ Crying spells
❑ Depressed (sadness)
❑ Difficulty having fun
❑ Difficulty making friends
❑ Disturbing memories
❑ Divorce
❑ Dizziness
❑ Drugs
❑ Easily distracted
❑ Education
❑ Excessive boredom
❑ Fainting spells
❑ Family or step-family relationships
❑ Fatigue
❑ Feel lonely
❑ Feel panicky
❑ Feel numb or cut off from emotions
❑ Feel "on top of the world"
❑ Feel ashamed
❑ Feel distant from God
❑ Feel fat
❑ Feel guilty
❑ Feel inferior
❑ Financial problems
❑ Health concerns
❑ Hyperactive
❑ Inability to control thoughts
❑ Insomnia (unable to sleep)
❑ Lack of motivation
❑ Learning/academic difficulties
❑ Legal matters
❑ Lose time
❑ Loss of interest in sex
❑ Memory problems
❑ Nightmares
❑ No appetite/excessive appetite
❑ Non-family relationship problems
❑ Palpitations
❑ Parent/child relationship problems
❑ Poor home environment
❑ Problems with alcohol
❑ Problems with prescription drugs
❑ Religious/Spiritual concerns
❑ Self-control issues
❑ Sexual identity concerns
❑ Sexual problems
❑ Sleeping all the time
❑ Spouse problems
❑ Suicidal urges/thoughts
❑ Suspicious of other people
❑ Take sedatives
❑ Tense feelings
❑ Tremors
❑ Unable to relax
❑ Unable to sit still
❑ Other _____
❑ Other_____
❑ Other_____