CENTER FOR INTEGRATED
BEHAVIORAL HEALTH

NEW CLIENT QUESTIONNAIRE (Adults)

Date_____

Identifying Information:

Name: _____

Address: _____

City_____ State_____ Zip _____

DOB: _____ SS#_____

Marital Status _____ Gender M F

Ethnicity _____ Religion _____

Home Phone _____ Can we leave a message at this number Y N

Work Phone _____ Can we leave a message at this number Y N

Cell Phone _____ Can we leave a message at this number Y N

Email: _____ May we contact you via email? Y N

How do you prefer to be contacted _____

Insurance Information:

Insurance Carrier: _____ ID#_____

Insurance Holder name: _____ Relation_____

Group#_____ Insurance Holder Date of Birth: _____

Emergency Contact Information:

Emergency Contact_____ Ph#_____

Relationship _____

Presenting Concerns:

What brings you in for services? _____

_____

_____

MEDICAL INFORMATION:

Primary Care Physician _____ Phone #: _____

Address _____

City _____ State _____ Zip_____

PAST MEDICAL HISTORY: Please circle any current or past experiences with the following.

Anemia
Atrial Fibrillation
Asthma
HIV/AIDS
Shortness of breath
COPD
Chronic Pain
Chronic Cough
Skin problems
Glaucoma
Sickle Cell
Fatigue
Heart Attack
Seizures
Sexual dysfunction

Problems with Vision
Hearing Difficulties
Numbness/Tingling
Head Injuries
Stomach Ulcer
Nausea/Vomiting
Cancer
Heartburn/Reflux
Stroke
Chronic Lung Disease
Hernia
Thyroid Disease
Colon Polyps
Headaches
High Blood Pressure
Transfusions

Congestive Heart Failure
Inflammatory Bowel Syndrome
Weight Gain
Irritable Bowel Syndrome
Weight Loss
Sleep Difficulties
Diabetes
Jaundice
Kidney/Bladder Problems
Diverticulosis
Pacemaker
Emphysema
Pancreatitis
Liver Disease
Other: _____

PAST SURGICAL HISTORY: Please identify any significant surgeries:

_____

_____

_____

CURRENT MEDICATIONS:

Medication	Dosage/Frequency	Condition	Prescribing Physician

PREVIOUS BEHAVIORAL HEALTH SERVICES: (Such as with a Psychologist, Social Worker, Psychiatrist, Counselor or Psychological testing).

With Whom	**When**	**Type of Treatment**	**Were you hospitalized? Where?**

CURRENT LIVING SITUATION: Who is currently living with you?

Person Age Relationship

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____