Yvonne Venger, LCSW
Wellbeing Within Therapy San Diego

New Client Information Form

Name_____

Nickname of Preferred to be Called_____

Address_____

_____

Phone Number(s) where I can leave a message for you:

Home:_____ Work_____ Cell_____

Date of Birth_____ Gender Identity_____

Marital/Partner Status_____

Name of Spouse/Partner_____

List the members of your household_____

_____

Person to call in case of emergency_____

Number_____

Relationship to you_____

Occupation_____ Employer_____

Reason for Today's Visit_____

_____

_____

Previous experiences with therapy and dates_____

_____

Have you ever had inpatient treatment for mental illness or substance abuse?

Yes_____ No_____

3252 Holiday Court, Suite 105, La Jolla, CA 92037 (858) 450-9112 yvenger@gmail.com

If yes, when and where?_____

_____

Do you have a medical care provider?

Yes_____ No_____

Name of Provider_____

Phone Number of Provider_____

Date of last physical exam_____

On the back of this form, please let all the medications and supplements that you are taking, your reason for taking them, and who prescribes them. Include all the prescription medications, over the counter drugs, vitamins, supplements, and herbs that you use.

How much alcohol do you drink and frequency_____

How much tobacco do you use and frequency_____

How much marijuana do you use and frequency_____

Street drugs: type_____ amount_____
Frequency_____

Date last used:

Alcohol_____ Marijuana_____ Street drug_____

List the last grade or degree you completed_____

Are you part of a faith community or another organization that provides support?

If yes, what is it?_____

Do you exercise regularly? Yes_____ No_____

If yes, indicate what you do and how often_____

_____

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Please indicate whether any of the following are now or have been stressors in your life:

Disruptions in your childhood_____

Divorce_____

Physical, Sexual, Emotional Abuse_____

Domestic Violence_____

Substance abuse or addiction_____

Caregiver with mental illness_____

Caregiver with other problems_____

Difficulties in school_____

Disturbed sibling relationships_____

Disturbed peer relationships_____

Significant illness or health problems:

For you_____

For others in your life_____

Spouse/Partner stresssors_____

Occupational/Financialstressors_____

Other stressors_____

Legal Problems_____

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Tell me more about your family. List their names and ages below.

Spouse/Partner_____

Mother_____

Father_____

Siblings_____

_____

Children_____

_____

What do you see as your strengths?_____

_____

What do you consider your weaknesses?_____

_____

Goals for Treatment_____

_____

_____

Motivation for Treatment_____

Expectations of significant others_____

_____

What cultural or spiritual experiences do you feel would be helpful in your treatment?_____

How did you hear about my practice?_____