

# Bridges Counseling Center

9253 Sierra College Blvd., Suite 100 Roseville, CA 95661

**JAMIE MILLER, LMFT**  
Licensed Marriage & Family Therapist

## NEW CLIENT INFORMATION

Client Name \_\_\_\_\_ Today's Date \_\_\_\_\_

(To be completed by the Parent/Guardian if client is younger than 18 years)

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Email address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number(s) Home \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

May we call you: at Home? \_\_\_\_ yes \_\_\_\_ no on Cell? \_\_\_\_ yes \_\_\_\_ no on Other? \_\_\_\_ yes \_\_\_\_ no

Relationship Status: Single \_\_\_\_\_ Married – Date \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_  
(Circle one) Widowed \_\_\_\_\_ Living together \_\_\_\_\_

People living in home/ages \_\_\_\_\_ Children not in home/ages \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

School/Grade: \_\_\_\_\_

### Person to be contacted in case of an emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone number \_\_\_\_\_ Work phone number \_\_\_\_\_

### Presenting Problem(s):

Please describe your reasons for seeking counseling (include date the problem started):

\_\_\_\_\_

\_\_\_\_\_

Goals for Therapy: \_\_\_\_\_

\_\_\_\_\_

How did you hear about us?

\_\_\_\_\_

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Client Name \_\_\_\_\_

## Medical History:

Please list any prescription medications you currently use:

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Please list any medical conditions (past or current) that the therapist should be aware of:

When did you last have a physical examination? \_\_\_\_\_

Who did you see? \_\_\_\_\_  
Name Phone Number

## Psychiatric History:

Have you ever received psychological or psychiatric treatment of any kind before?  Yes  No

If you answered yes to the above question, please answer the following:

What type of care did you receive?  Inpatient (hospital)  Outpatient  Both

When were you in treatment? \_\_\_\_\_

Where were you in treatment? \_\_\_\_\_

How long were you in treatment? \_\_\_\_\_

Who was your therapist or doctor? \_\_\_\_\_

Did your doctor prescribe medicine at this time?  Yes  No  not applicable

If Yes, what was prescribed (include dosages if known)? \_\_\_\_\_

## Family History:

Describe any significant emotional, medical or chemical dependency conditions of your parents and/or other family members:

## Substance Use History:

Have you ever abused drugs or alcohol?  Yes  No If yes, please describe:

Substances	Amount	Frequency	When? (First use; Last use)
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received substance abuse treatment or any kind before?  Yes  No

Do you have a history of blackouts, seizures, or withdrawal symptoms?  Yes  No

Please describe anything else you would like your clinician to know:

Habits:	Amount Currently Using	Most Ever Used
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol	_____	_____

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**PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:**

	No effect	Little effect	Some effect	Much effect	Significant effect	N/A
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A

If your eating habits are affected, describe how: \_\_\_\_\_

Sleeping Habits	1	2	3	4	5	N/A
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If your sleeping habits are affected, describe how: \_\_\_\_\_

Sexual functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your temper	1	2	3	4	5	N/A