Department of Psychology
Behavioral Health and Wellness Clinic
Box 70416; Johnson City, Tennessee 37614
423-439-7777 (voice) 423-439-7780 (fax)

New Client Information Form

Please fill out <u>all</u> information <u>as it applies to the person seeking treatment</u>. Please write N/A if the question does not apply to you.

Today's Date: _____

Note: Have you ever been a patient here before? ❑ No ❑ Yes
If yes, did you have a different name before? ❑ No ❑ Yes If yes, what was it before? _____
Who referred you to the clinic? _____

A. Identifying Information

Client's Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Parents' Names (if client is a child): _____ Name of Legal Guardian: _____

Nickname: _____ Social Security #: _____

What is your ethnicity, national origin, race or other important way you identify yourself : _____

Home Street Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone 1: _____❑ Home ❑ Cell ❑ Work Is it OK to leave a message using our Clinic name? ❑ No❑ Yes

Phone 2: _____❑ Home ❑ Cell ❑ Work Is it OK to leave a message using our Clinic name? ❑ No❑ Yes

Phone 3: _____❑ Home ❑ Cell ❑ Work Is it OK to leave a message using our Clinic name? ❑ No❑ Yes

Calls will be discreet, but please indicate any restrictions: _____

B. Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____ Relationship: _____

Address: _____

C. Developmental History ***(complete this section if the client is <u>under the age of 12</u>)***

Pregnancy and Delivery:

Prenatal medical illnesses and health care: _____

_____

Was the child premature? ❑ No ❑ Yes. Weight and height at birth: _____ pounds _____ inches

Any birth complications or problems? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

Early Development (first few months of life):

In the first few months of life did the child have any allergies? ❑ No ❑ Yes. If yes, please

list:_____

Please describe sleep patterns or problems: _____

_____

_____

Temperament (Usual Emotional Expression/Behavior):

_____

_____

Milestones (at what age did this child do each of these?):

Walked on own: _____ Stayed dry all day: _____

Stayed dry all night: _____ Used toilet regularly: _____

Speech/language development

Age when child said first word understandable to someone outside the family: _____

Age when child said first sentence understandable to someone outside the family: _____

Any speech, hearing, or language difficulties?

_____

_____

D. Brief Health Information *(<u>ALL</u> clients should complete the sections below)*

Where do you get your medical care?
Clinic/Doctor's Name: _____ Phone: _____

Address: _____

If you enter treatment here, may we communicate about your issues with your medical doctor so that s/he can be fully informed and we can better coordinate your treatment? ❑ No ❑ Yes

Starting with your childhood and proceeding up to the present, please list allergies, major diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. Continue on back of page if you need more space. For women please include if you have ever been pregnant? ❑ No ❑ Yes and any difficulty with your monthly cycle and or reproductive difficulties?

Age	Illness/Diagnosis	Doctor/Hospital Needed?	What Happened as a Result?
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	
		❑ No ❑ Yes	

Additional Comments:

_____

_____

Medication History (Please list ***all*** medications, drugs, or other substances you take or have taken in the last 6 months—prescribed, over-the--counter vitamins, herbs, and others). Continue on back of page if you need more space.

Medication/Drug	Dose (How Much?)	What Issue/Problem Do You Take it For?	Who Is It Prescribed By?	Taken as Prescribed?

Are there any other medical or physical problems you are concerned about? ❑ No ❑ Yes If yes, please explain: _____
_____
_____
_____

E. Education and Training: Continue on back of page if you need more space.

Dates From	To	School Name and Type	Special Classes?	Adjustment to School	Did You Graduate?
			❑ No ❑ Yes	❑ Good to Great ❑ Okay ❑ Problems	❑ No ❑ Yes
			❑ No ❑ Yes	❑ Good to Great ❑ Okay ❑ Problems	❑ No ❑ Yes
			❑ No ❑ Yes	❑ Good to Great ❑ Okay ❑ Problems	❑ No ❑ Yes
			❑ No ❑ Yes	❑ Good to Great ❑ Okay ❑ Problems	❑ No ❑ Yes
			❑ No ❑ Yes	❑ Good to Great ❑ Okay ❑ Problems	❑ No ❑ Yes

F. Military History: Continue on back of page if you need more space.

Dates From	To	Branch	Stationed Where?	Highest Rank	Ever Lose Rank?	Job Title or Duties	Type of Discharge?
					❑ No ❑ Yes		
					❑ No ❑ Yes		
					❑ No ❑ Yes		
					❑ No ❑ Yes		

G. Employment History (for the last 10 years): Continue on back of page if you need more space.

Dates From	To	Name of Employer	Job Title or Duties	Reason for Leaving

H. Legal Problem History: Continue on back of page if you need more space.

Have you ever been convicted of a crime? ❑ No ❑ Yes If yes, please explain._____

_____

_____

_____

Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes If yes, please explain:_____

_____

_____

_____

Is your reason for coming to the BHWC related to an accident or injury? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

_____

I. Additional Information: Continue on back of page if you need more space.

Is there any other information you think we should know**?** ❑ No ❑ Yes If yes, please explain: _____

_____

_____

_____

_____

_____

_____

_____

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.