NEW MINDFUL LIFE

PO Box 34494, San Diego CA 92163
(619) 261-8510

CONFIDENTIAL CLIENT INFORMATION FORM

Client Name: _____ Date of Consultation: _____

Age: _____ Birthdate: _____ Home Phone: _____ Work Phone: _____

Cell Phone:_____ Telephone number you prefer to be contacted at: _____

Home Address: _____

Email: _____

Occupation: _____ Title / Position at work:_____

Employer: _____ Employer Address: _____

Relationship status / living situation:_____

Spouse / Partner Name: _____Home Phone: _____Work phone:_____

Children: Names and ages

Your family of origin: Names and ages of your parents and siblings

Emergency contact person: _____

Phone: _____ Relationship to you: _____

QUESTIONNAIRE

What brings you here today?

Why are you seeking therapy at this time?

Please describe how your life is currently being affected by your current circumstances /problems/stresses:

What goals would you like to accomplish in your psychotherapy?

Please circle areas of your life that are being affected:

Your Primary Relationship (e.g.: marriage, partnership)	Social/Personal Relationships	Work Relationships
Family member relationships	Occupation Performance	Education/ School
Domestic Violence	Housing Problems	Financial Problems
Medical Problems	Problems with Sexual Abuse	Health
Problems with Physical Abuse	Parenting Challenges	Other

CIRCLE THE ITEMS THAT YOU HAVE EXPERIENCED <u>OVER THE PAST MONTH,</u> AND/OR ARE <u>CURRENTLY EXPERIENCING</u>:

Headaches	Overeating	Loneliness
Constipation	Excessive urination	Blushing
Itching	Cold hands or feet	Suicidal thoughts
Faintness or dizziness	Loss of sexual interest or desire	Violent thoughts
Hot flashes	Twitches, tics, spasms	Violent behavior
Dry mouth	Lump in throat	Self-Mutilation
Tightness in jaw	Stuttering	Suicidal attempts
Muscle soreness	Grinding of teeth	Sweaty palms
Weakness in parts of your body	Lower back pains	Pains in heart or chest
Heavy feelings in arms or legs	Feeling bored	Allergies
Cannot motivate yourself to do things you usually enjoy	Checking things repeatedly before leaving the house	Uncontrollable outbursts of temper
Feeling tense or nervous	Nausea	Fatigue
Shakiness	Tingling sensation in hands or feet	Preoccupation with death
Bloatedness	Burning or upset stomach	Bad dreams
Trouble getting your breath	Your mind going blank	Extreme fear of places or events
Difficulty making decisions	Feeling fearful	Trouble remembering things
Feeling inferior to others	Thoughts hard to get rid of	Difficulty concentrating
Difficulty falling asleep or staying asleep	Thoughts of ending your life	Poor appetite

Worrying about things	Easily annoyed or irritated	Loss of interest in things
Crying easily	Difficulty in getting up in the morning	Loss of sexual functioning
Neck Pains / Tension	Shoulder Pain / Tension	Ruminating about difficulty in life
Other:		

Past & Current Experiences

Therapy

Names and dates of previous therapy experience(s):

Has your previous therapy been a helpful, positive experience for you? Please explain:

Health information & history

Name of your current physician: _____

Phone: _____

When was your most recent visit to your physician? _____

Psychological history: trauma, abuse, major crises, and unusual circumstances:

Psychiatric history: diagnosis. treatments (including medications, if applicable), hospitalizations:

Please explain any family psychiatric history:

Have you ever had suicidal thoughts? ____ Have you ever made a suicide attempt? ____ If yes, please describe:

Have you ever felt homicidal, or felt physical aggression towards another? _____If yes, please describe:

Please describe your general health: major illnesses (past or present), pain, and chronic symptoms.

Do you have history or currently experience any of the following?

Heart Disease	Irritable Bowel Syndrome	Chronic Pain
Arthritis	High Blood Pressure	Thyroid Problems
Migraine Headaches	Arteriosclerosis	Stroke
Hepatitis	Hormonal Problems	Diabetes
Cancer (Type _____)	Eating disorders	Inflammatory Bowel Disease (Crohn's or Colitis)

Please list any medications you are currently taking (including dosages), and by whom prescribed:

Do you suffer from premenstrual syndrome? _____If yes, how many days before your period starts do your PMS symptoms begin? _____Do you suffer from mood changes premenstrually? _____

If yes, please describe them and their severity:

Daily habits

How many hours of sleep do you average per night?_____

Do you sleep as well as you would like to?_____

Do you have difficulty falling asleep , staying asleep , or waking up (circle all that apply); provide details

Please indicate any alcohol use, and/or recreational drug use (past or present):

If you currently drink alcohol or engage in recreational drug use, what kind and how often?

_____

Do you use Tobacco (cigarettes. pipe. cigar)? _____
Date began and how many per day? _____

If you do not currently smoke, did you ever smoke, and if so, describe for how long and how many per day, and when you quit:

Do you drink caffeine? _____ Type/How often? _____

How would you describe your eating habits? 3 meals per day, snacks, fast food?

Have you ever struggled with body image issues?_____ If yes, please explain?

Self-care

What kinds of things do you do for self –care (to relax, nurture yourself, relieve stress, etc)?

Have you ever been concerned that some of your self- care activities are not good for you?_____ If yes, please explain:

How stressful is your life right now: ___Not ___Mildly ___Moderately ___Severely

How often and how long do you exercise? _____

What type of exercise do you do? _____

Do you practice meditation? Please detail understanding or experience with mindfulness

Do you have faith-based spiritual practices? Please detail experiences over life with spirituality

NATURE QUESTIONNAIRE

What is your pace of life? Too slow- not enough activity? Too fast- too much activity?Explain.

What amount of time do you spend in non-natural settings- indoors at home, work, stores?

How much time do you spend a day on screens (phones, tablets, TV, computers)- at work and for leisure?

Any ecological anxieties or grief? Concerns about climate change, farming practices, pesticides, industrialization etc.

Do you have an awareness or connection to food? Consider your pace of eating, time spent cooking, reflect on

where your food comes from…

What types of environments do you enjoy? Consider natural light, clutter, spaciousness, small or large spaces, indoors or outdoors…

How much time do you spend outside?

What types of experiences do you enjoy when you are in the nature?

How does or how can nature support you?

Is there anything else you'd like to mention about yourself that you feel is important to your experience in therapy?

Who may I thank for referring you to me? _____

YOUR SIGNATURE: _____

TODAY'S DATE: _____