ADULT BACKGROUND INFORMATION

Welcome to New Leaf Clinic. Please answer all questions as completely as possible. Information given is strictly confidential and beneficial in providing you with the best possible service.

Name: _____ Date:_____

Gender: Male ___ Female ___ Date of Birth _____/_____/_____ Age _____

Ethnicity:

___ African American	___ Bi-racial	___ Hispanic/Latin
___ Asian	___ Caucasian	___ Native American
___ Other		

Home Phone: _____ (Okay to call? Yes/No Okay to leave message? Yes/No)

Work Phone: _____ (Okay to call? Yes/No Okay to leave message? Yes/No)

Cell Phone: _____ (Okay to call? Yes/No Okay to leave message? Yes/No)

Email: _____

Address: _____
Street City/State Zip

Alternate Address (if applicable): _____
Street City/State Zip

Emergency contact:

_____ _____ _____
Name Relationship Phone number

_____
Email address

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? Yes No

If so, we may need your permission in order to communicate with that individual or agency.

Previous Mental Health Professional/Agency: _____

Address: _____

Phone number: _____ Dates of Service: _____

Have you ever been hospitalized for mental health concerns? Yes No

If yes, when? _____ Where? _____

How did you hear about New Leaf Clinic?

___ Health Professional ___ School ___ Website ___ Friend ___ Other

CURRENT CONCERNS

Please list all your current concerns:

_____

_____

_____

Which issue is of primary concern and when did it begin? _____

How have you attempted to deal with this issue in the past? _____

FAMILY ATMOSPHERE

Circle the number on the Likert scale that best describes the family atmosphere in your **family of origin**:

Very lenient	1	2	3	4	5	Very strict
Non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Structured
Inconsistent	1	2	3	4	5	Consistent
Low expectations	1	2	3	4	5	High Expectations

Level of Family Support (from friends, relatives, church, school, etc):

Hardly any support	1	2	3	4	5	Considerable support

GENERAL INFORMATION

List your current family makeup, beginning with the oldest member, and **include yourself.**

Name	Relationship to client	Age
Name	Relationship to client	Age
Name	Relationship to client	Age
Name	Relationship to client	Age
Name	Relationship to client	Age
Name	Relationship to client	Age
Name	Relationship to client	Age

PERSONAL HISTORY

For each of the following items that apply, write in your approximate age at the time it occurred. If not applicable, leave blank.

_____ Academic problems
_____ Discipline problems
_____ Victim of bullying
_____ Bullying others
_____ Anxiety/Severe worrying
_____ Aggressive behavior
_____ Impulsive
_____ Difficulty making friends
_____ Frequent injuries
_____ Difficulty toilet training
_____ Speech/language problems
_____ Victim of abuse
_____ Chronic ear infections
_____ Asthma
_____ Chronic stomach aches
_____ Refusal to speak in certain situations
_____ Severe food aversions/refusal to eat
_____ Tics or nervous habits
_____ Obsessive thoughts/compulsive behaviors
_____ Extreme sadness/suicidal thoughts
_____ Attention problems
_____ Extremely active/as though driven by a motor
_____ Lack of Respect for Authority Figures
_____ Alcohol/drug use
_____ Aggressive toward animals
_____ Difficulty learning letters and sounds
_____ Night Terrors
_____ Eustachian tubes
_____ Chronic bedwetting (age 4 and above)
_____ Chronic headaches
_____ Major Illnesses/Hospitalizations (explain):

_____

_____ Other (explain)
_____

HEALTH

Primary Care Physician: _____

Address: _____

Phone number: _____

Date of LAST complete physical or "well-check": _____

Have you been diagnosed with a physical disability or chronic illness? Yes No

(If yes, explain) _____

If you are currently taking medication for physical or mental health-related conditions, please indicate the medication name, diagnosis, dosage, and date of diagnosis below.

Medication	Dosage	Diagnosis	Date of diagnosis
Medication	Dosage	Diagnosis	Date of diagnosis
Medication	Dosage	Diagnosis	Date of diagnosis
Medication	Dosage	Diagnosis	Date of diagnosis