Julie Wells, M.S.
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NEW CLIENT ASSESSMENT

Name: _____

D.O.B. _____ Gender: _____ Date: _____

Home Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cellular Phone: _____

Email Address: _____

Contact in Emergency Situation: _____

Telephone Number: _____ Relationship: _____

What concern/s brings you to counseling? _____

_____

_____

How did you find me? _____

(Psychology Today, Theravive, Google Search, Yelp, Referral, etc.)

To be completed if Client is a Minor:

Parent/Guardian: _____

Contact Information:_____

If parents are divorced, who has legal custody? _____

MEDICAL HISTORY

Currently under a medical physician's care? YES/NO

If YES, please describe current medical condition/s: _____

_____

_____

Medications currently used: circle if NONE

Medication	Dosage	Dr. Prescribing	Why Prescribed
_____	_____	_____	_____
_____	_____	_____	_____

Previous Counseling or Chemical Dependency Treatment/Services: NONE

Facility/Therapist's Name	Date of Service	Reason for Treatment	Helpful (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____

CHEMICAL DEPENDENCY ASSESSMENT

Have you ever attempted to reduce your alcohol intake? Y N

If yes, what was the outcome? _____

Do you ever use illegal drugs? Y N

If yes, please list/describe illegal drugs you currently use: _____

_____

PERSONAL QUESTIONS

Have you ever attempted suicide or to seriously harm yourself? Y N

Do you currently feel suicidal (i.e., have thoughts of harming yourself in any way)? Y N

If yes, please describe your feelings/intent: _____

_____