New Client Registration

Today's date ___________________
Name___________________________________Age___________________Sex________
Address __________________________________
__________________________________ Date of birth __________________
Home phone___________________May I call you at this number? y / n Leave a message? y / n
Other numbers at which I can call you _________________________Can I leave a message? y / n
Person responsible for bill _________________________ Relationship________________
Address: ____ Phone ____________________

Employer Information:
Employer ___________________________ Occupation________________________
Address____
Phone #: ________________May I call? y / n Leave message? y / n

Household/Relationship Information:
Spouse/Partner Name _________________ Relationship _______Resides with you? y /n
Social security # ______________ Employer: __________________ Wk ph #____________
Dependents Name _______________________ Birthdate ___________ Age___ Sex ____
Name _______________________ Birthdate ___________ Age___ Sex ____
Name _______________________ Birthdate ___________ Age___ Sex ____
Others living in household ____________________ Relationship______ Age____Sex___
____

Insurance Information:
Primary Insurance Company ____________________________ Group # ______________
Name of subscriber __________________ Subscriber # (include prefix)__________________
Address ____ Telephone # ___________
Managed care company (if applicable) ____
Address:_____________________________________ Telephone # ___________________
Secondary Insurance Company __________________________ Group # __________
Name of subscriber __________________ Subscriber # __________Date of birth_______
Address ____ Telephone # ___________
Managed care company (if applicable) ____
Address:_____________________________________ Telephone # ___________________

Medical and Referral Information:
Name of Physician: ___________________________ Date of last physical___________
Medications you are currently taking____
By whom were you referred to my office?______________________Relationship ______
Address _____________________________________ Phone ________________________
Emergency Contact ___________________________ Relationship __________________
Address ____
Home phone # ___________________________Work phone # ______________________
Legal next of kin _________________________ Relationship ______________________
Address __________________________________ Home # ___________ Work # _______

Do not write below this line

DSM IV Code: Primary ___________________ Secondary _________________

Clinical Information

Ellen A. Begley, Ph.D.
3429 Fremont Ave N. #316 , Seattle, WA 98103
206-650-4504

Name ____New Client Information

Please fill out the following clinical/background information. If there is not enough room for your answer add pages as needed or write on the back of the form pages. If you have any questions or feel uncomfortable answering a question please star it and plan to discuss it with Dr. Begley during your first visit.

Feelings/ Symptoms

Please place a check mark beside the following feelings or symptoms that have been present for you in the last two weeks and place two check marks next to those items that are most pronounced for you.

__Change in appetite
__Significant weight gain
__Significant weight loss
__Feel agitated or restless
__Feel slowed down or sluggish
__Feel guilty a lot
__Unable to concentrate
__Withdrawing from other people
__Withdrawing from your usual activities
__Thoughts of death or dying
__Thoughts of suicide
__Intentions of suicide
__Loss of energy
__Feel hopeless about the future
__Feel irritable
__Depressed mood
__Feel very angry at others
__Trouble controlling your temper
__Thoughts of harming someone else
__Intentions of harming someone else
__Hearing voices
__Seeing things others don't see
__Easily distracted
__Disorganized
__Procrastinate often
__Impatient
__Unhappy with weight/appearance
__Loss of close relationship
__Wonder whether to stay in close relationship
__Purposefully cut or hurt your body
__Feel overwhelmed by your emotions
__Sudden shifts in mood
__Sleep problems
__Nightmares
__Food bingeing
__Food purging
__Headaches
__Racing heart
__Sweating
__Shortness of breath
__Fear of choking
__Chest pain
__Nausea
__Dizziness
__Fear of losing control
__Fear of dying
__Numbness
__Chills or hot flashes
__Feel detached from self
__Muscle tension
__Unwanted repetitive thoughts
__Unwanted repetitive habits
__Spending money excessively
__Drinking excessively
__Taking risks you regret later
__Afraid of rejection
__Easily influenced by others
__Feelings get hurt easily
__Having trouble expressing feelings
__Have difficulty trusting others
__Afraid of making mistakes
__Feel nobody understands you
__Feel talked about or made fun of
__Feel you don't have close friends
__Feel inferior
__Feel empty
__Feel anxious
__Distressing dreams
__Body aches/pains
__Avoiding important things
__Menstrual problems
__Menopause symptoms

MAIN PROBLEMS:

Name ____New Client Information

Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below.

1----------2---------3---------4---------5---------6---------7---------8---------9---------10
No Problem Mild problem Moderate Problem Severe Problem Couldn't be worse

Rating:

1. ____ _____

2. ____ _____

3. ____ _____

Briefly describe what motivated you to seek therapy at this time (rather than sometime earlier or later): ____
____

What personal strategies have you previously used to try to remedy these problems? __
____
____

Do you have thoughts of killing or harming yourself? Yes No
Is there a history of domestic violence in any of your current relationships? Yes No

HEALTH/MEDICAL ISSUES

1. Do you have any serious medical conditions? No Yes (If yes describe) ___________

---

2. How would you rate your overall health? Excellent___ Good___ Fair___ Poor ___

3. Please list any medication (including dosages) that you are taking:
____
____
____

4. How many: visits to physician in past year __ Sick days in past year __
Therapy sessions, ever ___ Cigarettes: packs a day___
Alcohol (estimated use): # Drinks a day ___ Caffeine: Cups per day__
Drinks a week___
Drinks a month___

5. Mark all that have resulted from your use of alcohol/drugs:
__traffic ticket/violation ___fight with a friend ___financial problems
__relationship problems/ending ___blackouts ___work/school problems
__physical violence __verbal conflicts ___health problems

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CURRENT STRESSFUL EVENTS

Listed below are some of the sources of stress that clients sometimes feel. Please circle the number that represents the amount of stress you currently feel in each area. (1=very little stress, 10=very high stress). Briefly describe the two items you rated as most stressful.

	Very little stress									Very high stress
1. Work or school	1	2	3	4	5	6	7	8	9	10
2. Personal relationships	1	2	3	4	5	6	7	8	9	10
3. Family of origin issues	1	2	3	4	5	6	7	8	9	10
4. Parenting responsibilities	1	2	3	4	5	6	7	8	9	10
5. Financial Concerns	1	2	3	4	5	6	7	8	9	10
6. Legal Concerns	1	2	3	4	5	6	7	8	9	10
7. Health Concerns	1	2	3	4	5	6	7	8	9	10
8. Sexual Concerns	1	2	3	4	5	6	7	8	9	10
9. Self-esteem	1	2	3	4	5	6	7	8	9	10
10 Body image	1	2	3	4	5	6	7	8	9	10
11. Grief/Recent losses	1	2	3	4	5	6	7	8	9	10
12. Other	1	2	3	4	5	6	7	8	9	10

Description/Comments (on the two most stressful) ______________________________________
____
____
____

BACKGROUND INFORMATION

Education History

Highest grade completed in school: ______________________________

Any difficulties with learning: __________________________________

List all schools attended:

School Name	**Degree**	**Date**

Employment History:

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List all the occupations you have held along with the approximate dates of employment:

Job **# of years** **Date**

____
____
____
____
____

In my family, there is a history of (mark all that apply):

__substance abuse __domestic violence/abuse
__sexual abuse __emotional abuse
__eating disorders __ learning problems
__depression __suicide attempts
__completed suicide __hospitalization for psychiatric reasons

Have you ever been afraid of your spouse/significant other? Yes No Somewhat

Have you ever had an unwanted sexual experience? Yes No Somewhat

Have you tried harming yourself in the past? Yes No Somewhat

Have you harmed others in the past? Yes No Somewhat

Worst time in life (please briefly describe) _____________________________
____
____

Who helped you through it? ____

Best time in life/when were you most proud? (please briefly describe)
____
____
____

With whom did you share this time? __________________________________
____

What are your STRENGTHS? ____
____
____

How do you cope when times are hard?____
____
____

Anything else you'd like me to know____
____
____

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