New Client Information

River City Clinic ** 651-646-8985
1360 Energy Park Drive, Ste 340, St. Paul, MN 55108

Welcome! In order to get to know you and to better serve you, I need to know some things about you and your family. Please answer each question as completely as you can.

Name:_____ Date of Birth: _____ Age: _____

Occupation: _____Employer:_____

If student, please list school, field of study and which degree you're working toward:

_____

How did you find out about my services?_____

Relationship Status**:**

( ) Single

( ) Long term relationship for _____ years

( ) Married for _____ years

( ) Separated after a marriage of _____ years

( ) Divorced for _____ years after a marriage of _____ years

( ) Remarried for _____ years

( ) Widowed after a marriage of _____ years

Spouse/partner's first name: _____Occupation: _____

Family Information:

Father's name: _____ Alive? _____ Age: ____ Occupation: _____

Mother's name: _____Alive? _____ Age: _____ Occupation: _____

What is/was your parent's marital status?

( ) married ( ) divorced ( ) separated ( ) father remarried ( ) mother remarried

First name, age, and sex of any siblings and step siblings you have:

_____

_____

First name, date of birth, and sex of any children you have:

_____

_____

Who do you live with?

_____

Education:

Please indicate your highest education level:

( ) Less than high school ( ) High school equivalent/GED ( ) High school diploma

( ) Vocational ( ) Some college ( ) Bachelor's degree

( ) Master's degree ( ) Doctoral degree ( ) Other:_____

Major/minor/area of concentration_____

Did you experience any learning problems in school? yes ( ) no ( )

If yes, please describe: _____

Personal Strengths:

What do you do well and what activities do you enjoy?

_____

What personal qualities would others say you have?

_____

What kinds of support systems (connections) do you have in your life?

_____

Legal Issues:

Please list any legal issues that are affecting you or your family right now, or have had a significant effect on you in the past?

_____

Mental Health History:

Have you previously seen a counselor/therapist/psychologist? ( ) yes ( ) no

If yes, please fill in the following information:

Name of professional	Dates of service	Reason for service
_____	_____	_____
_____	_____	_____
_____	_____	_____

What did you find most helpful in therapy?

_____

What did you find least helpful in therapy?

_____

Have you ever been hospitalized for psychiatric reasons? ( ) yes ( ) no

Is there a history of mental illness in your family? ( ) yes ( ) no

If yes, please explain

_____

_____

_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Substance Use:

Please check substances you use on a weekly/monthly basis:

( ) Alcohol ____ x per week/month – How many drinks per day?

( ) Marijuana ____ x per week/month

( ) Caffeine ____ x per week/month – How many drinks per day?

( ) Tobacco, type: _____ ____ x per week/month

( ) Other & amount used: _____

( ) Other & amount used: _____

( ) Other & amount used: _____

Do you believe your use may be a problem? yes ( ) no ( )

Do you believe your partner's use may be a problem? yes ( ) no ( )

Current Issues:

Briefly describe the problems or concerns you are seeking counseling for:

_____

_____

_____

How long have these problems or concerns been present?

_____

In what ways have you attempted to cope with or solve this problem/concern?

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

_____

Family Concerns: (Please check any family concerns you are currently having)

( ) Fighting	( ) Disagreeing about relatives and/or friends
( ) Feeling distant	( ) Conflict with relatives and/or friends
( ) Loss of fun	( ) Alcohol use
( ) Lack of honesty	( ) Drug use
( ) Physical fights	( ) Infidelity
( ) Educational problems	( ) Money

( ) Other: _____

Is there anything else you think would be helpful for me to know?

_____

_____

_____

_____

_____

_____

Thank you!