NEW HOPE COUNSELING CENTER
126 East Hendron Chapel Road
Knoxville, TN 37920
(865) 579-9814

Date Received:_____ Therapist:_____

Name:_____ Phone:_(h)_____(m)_____

Address:_____

May we leave a message at your home number? ☐ Yes/ ☐ No _____ Please Initial

May we leave a message on your mobile phone? ☐ Yes/ ☐ No _____ Please Initial

When is the best time of day to reach you?_____

Date Of Birth:_____ Marital Status_____

Social Security Number_____

When did you first think about coming to counseling (Date) _____

Reason You Are Here Today:_____

_____

_____

How often do you notice this occurring? (If Applicable)_____

How does this affect your daily functioning?_____

Are there events, situations, or people that precipitate this?_____

_____

Have you been to counseling before? ☐Yes/ ☐No If yes, please provide dates of service:_____

_____

Who was your Therapist/Psychiatrist/Psychologist?_____

May we contact them? ☐Yes/ ☐No If yes, please list contact information_____

_____

Do you have health insurance? ☐Yes/☐ No If yes, please list provider name_____

Policy Number_____

Group Number_____

Please list the primary person/employer through whom the insurance is provided_____

Please list the toll free benefits eligibility number (found on back of card)_____

May we contact your health insurance provider? ☐ Yes/ ☐ No _____ Please Initial

May we contact your employee benefits department? ☐ Yes/ ☐ No _____ Please Initial

In the case of an emergency who would you like us to contact? _____

Please initial indicating you authorize us to contact this person in case of an emergency_____

What is this person's phone number/s?_____

Health History:

Do you have a Primary Care Physician? ☐Yes/☐ No If yes, what is his/her name?_____

May we contact your Primary Care Physician? ☐ Yes/ ☐ No _____ Please Initial

Where does your doctor practice?_____

Are you taking any medications, over the counter, or prescription? ☐Yes/☐ No

If yes, please list medications and dosages: (please include and vitamins or supplements)_____

_____

How would you describe your current health?_____

In your childhood were you diagnosed with:

☐ Depression ☐ asthma ☐ ear/nose/throat difficulties ☐ measles
☐ Mumps ☐ rubella ☐ chicken pox ☐ ADD/ADHD
☐ Other mental health diagnosis:
☐ Other serious illnesses, injuries or surgeries:_____

_____

Family Medical and Mental Health History

Father:	☐ alcoholism	☐ bipolar	☐ depression	☐ drug addiction
	☐ schizophrenia	☐ heart disease	☐ cancer (type: _____)	
	☐ suicide	☐ diabetes	☐ other:	
_____	☐Healthy	☐No known Issues_____		
Mother:	☐ alcoholism	☐ bipolar	☐ depression	☐ drug addiction
	☐ schizophrenia	☐ heart disease	☐ cancer (type: _____)	
	☐ suicide	☐ diabetes	☐ other:	
_____	☐Healthy_____	☐No known Issues_____		
	☐Healthy	☐No known Issues_____		
Grandfather Paternal	☐ alcoholism	☐ bipolar	☐ depression	☐ drug addiction
	☐ schizophrenia	☐ heart disease	☐ cancer (type: _____)	
	☐ suicide	☐ diabetes	☐ other:	
_____	☐Healthy	☐No known Issues_____		
Grandfather Maternal	☐ alcoholism	☐ bipolar	☐ depression	☐ drug addiction
	☐ schizophrenia	☐ heart disease	☐ cancer (type: _____)	
	☐ suicide	☐ diabetes	☐ other:	
_____	☐Healthy	☐No known Issues_____		
Grandmother Paternal	☐ alcoholism	☐ bipolar	☐ depression	☐ drug addiction
	☐ schizophrenia	☐ heart disease	☐ cancer (type: _____)	
	☐ suicide	☐ diabetes	☐ other:	
Grandmother Maternal	☐ alcoholism	☐ bipolar	☐ depression	☐ drug addiction
	☐ schizophrenia	☐ heart disease	☐ cancer (type: _____)	
	☐ suicide	☐ diabetes	☐ other:	
_____	☐Healthy	☐No known Issues_____		
Sister	☐ alcoholism	☐ bipolar	☐ depression	☐drugs
	☐ schizophrenia	☐ heart disease	☐cancer(type:_____)	
	☐ suicide	☐ diabetes	☐ other:	
	☐Healthy	☐No known Issues_____		

Brother	☐ alcoholism	☐ bipolar	☐ depression	☐drugs
	☐ schizophrenia	☐ heart disease	☐cancer(type:_____)	
	☐ suicide	☐ diabetes	☐ other:	
	☐Healthy	☐No known Issues_____		

Family History: (past/present relationship with family/significant others, family constellation, marital history)

Were you raised in a household with both father and mother present? ☐Yes/☐ No
If no to above question, how would you describe your relationship with the absent parent? ☐ close ☐ distant.
If both parents were not present, who were you raised by as a child?_____
Please indicate the number of siblings you have __ sister(s), __ stepsister(s), __ half-sister(s), __ brother(s), __ stepbrother(s), __ half-brother(s).
How would you describe your relationship with your family as ☐ close ☐ distant?
Which best describes your marital situation?
_____ never have been married and have no children.
_____ have been married _____ times(s) and have no children.
_____ have never been married but have __ child(ren) and the child(ren) reside(s) with _____.
_____ have been married __ time(s) and have __ child(ren). Relationship with child(ren) is described as ☐ close ☐ distant. Child(ren) reside(s) with _____
If you are married what is your spouse's name?_____
How long have you been married to your spouse?_____
How would you describe your relationship?_____

_____

How would you describe your sexual relationship?_____

_____

What are your children's name(s) and ages(s) if applicable?_____

_____

How would you describe your relationship with your children?_____

_____

Please List Significant Events that have occurred in your life during the following periods:

Infancy:_____

_____

Middle Childhood:_____

_____

Adolescence:_____

_____

Young Adulthood:_____

_____

Middle adulthood:_____

_____

Late adulthood:_____

_____

In the last month…

How many hours do you sleep per 24 hour period on average?_____

Has the number of hours per day of sleep changed? ☐Yes/ ☐No If yes, has it ☐Increased or ☐Decreased

Have you noticed a change in your appetite? ☐Yes/ ☐No If yes, has it ☐Increased or ☐Decreased

Have you had a change in the amount of time you spend worrying? ☐Yes/ ☐No If yes, has it ☐Increased or ☐Decreased

Have you noticed a change in your mood? ☐Yes/ ☐No If yes, has it ☐Elevated or ☐Depressed

Have you had thoughts to hurt yourself (including cutting)? ☐Yes/ ☐No

If yes, do you have a plan to hurt yourself? ☐Yes/ ☐No

Are you currently suicidal? ☐Yes/ ☐No

Have you ever attempted suicide? ☐Yes/ ☐No

Have you had thoughts to hurt others? ☐Yes/ ☐No

If yes, do you have a plan to hurt others? ☐Yes/ ☐No

Have you ever attempted to hurt someone else? ☐Yes/ ☐No

If yes, when and in what circumstance?_____

When you feel out of control, what helps you regain control?_____

_____

Are you now or have you ever been sexually active? ☐Yes/ ☐No

If yes to above question, are you currently sexually active? ☐Yes/ ☐No

Have you ever been a victim of sexual abuse? ☐Yes/ ☐No If yes, by_____ at age _____
Have you ever been a victim of physical abuse? ☐Yes/ ☐No If yes, by _____at age _____
Have you ever been a victim of emotional abuse? ☐Yes/ ☐No If yes, by _____at age _____
Do you have current domestic violence issues? ☐Yes/ ☐No If yes, Please explain:
Have you ever abused anyone in the following ways?

- ☐ Sexual abuse of _____ in (est. mo/year) _____.
- ☐ Physical abuse of _____ in (est. mo/year) _____.
- ☐ Emotional abuse of _____ in (est. mo/year) _____.

What is your related sexual preference?

☐ heterosexual ☐ homosexual ☐ bisexual ☐ other:

Do you have any fears of phobias? ☐Yes/ ☐No If yes, what are they?_____

_____

Thank you for the time and effort you took to complete this questionnaire. The information contained within will help us better understand ways to assist you. Please sign and date below indicating that to the best of your knowledge all information provided is true and accurate.

Signature:_____ Date:_____

Please Print Name:_____