Jeanie S. Kirk, MA, LPC, NBCCH, MPH
Licensed Professional Counselor (#001473)
Certified Clinical Hypnotherapist
2850 West Clay, Suite 255, Saint Charles, MO 63301
Phone: (636) 724 - 1731

NEW CLIENT FORM

Today's Date_____/_____/_____

Please provide the following information and answer the questions below. Please note that the information you provide here is protected as confidential information.

PERSONAL INFORMATION

Name (print):
_____
(Last/First/Middle Initial)

Birth Date: _____ /_____ /_____ Identified Gender: _____ Marital Status: _____

Address: _____
(Street/Number)
_____
(City/State/Zip)

Preferred Phone: (_____) - _____ May I leave a message? □ Yes □ No

Emergency Contact: Name: _____ Relationship _____

Phone: (_____) _____

Type of services desired: ____ Individual _____ Group _____ Couples _____ Family

→Briefly describe the problem, issue or concern that has led you to seek counseling:

_____

_____

_____

→What are your goals and expectations for your session(s) with Jeanie S. Kirk?

_____

_____

→Are you currently living in an environment in which you feel safe? □ Yes □ No

→Are you currently seeing another counselor? □ Yes □ No

→Which do you believe best describes your current emotional/psychological health? (*circle one of the following*):

Poor Unsatisfactory Satisfactory Good Very good

→Which do you believe best describes your current physical health? (*circle one of the following*):

Poor Unsatisfactory Satisfactory Good Very good

→How would you rate your current sleeping habits? (*circle one of the following*):

Poor Unsatisfactory Satisfactory Good Very good

→Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not applicable
Marriage/relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/school performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial situation	1	2	3	4	5	N/A
Physical health	1	2	3	4	5	N/A
Anxiety level/nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Alcohol/drug usage	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your temper	1	2	3	4	5	N/A

→ Would you say you currently experience significant stressors in your life that are not the concern/issue/problem you have brought to counseling? ☐ No ☐ Yes

If yes, please briefly describe these: _____

_____

→Are you currently concerned about your purpose or direction in life? ☐ No ☐ Yes

→How often do you feel anxious?

Never Almost never Often Very Often Always

→How often do you experience feelings of being down, hopeless, or feeling guilt or self-doubt?

Never Almost never Often Very Often Always

→How often do you experience feelings of anger, or worry you might lose control?

Never Almost never Often Very Often Always

→In the last 6 months, have you had a complete physical exam? ☐ Yes ☐ No

→Please list your current diagnoses (both mental and physical health):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

→List any prescription medications; over-the-counter medications; herbals; and/or supplements you are taking currently **AND** the prescribing practitioner if this is a prescription:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____
9. _____ _____
7. _____ _____

❖ *Please continue on the next page if necessary*

Client Signature _____ Date: _____/_____/_____

→Continue to list any prescription medications; over-the-counter medications; herbals; and/or supplements you are taking currently **AND** the prescribing practitioner if this is a prescription:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____
9. _____ _____
7. _____ _____

Client Signature _____ Date: _____/_____/_____