NEW CLIENT FORM

FOR PSYCHOTHERAPY (FLORIDA RESIDENTS ONLY)

Center for Self Balance, LLC • Joseph Noecker, MA, LMHC

Center for Self Balance

Date: _____/_____/_____

MY CONTACT INFORMATION

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PREFERRED METHOD OF CONTACT

Only include contact information that is okay for us to use. If NOT okay, please leave blank. Please keep us updated of any changes!

The best way to contact me is: ○ Home Phone ○ Mobile Phone ○ Work Phone ○ Other Phone ○ Email

It is okay to leave confidential messages for me: ○ Yes ○ No

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Other Phone: _____

E-mail:_____

ABOUT ME

Age: _____ DOB: _____/_____/_____ Race: _____ Gender: _____

Partner/Spouse Name: _____

How many people in your household? _____ Describe the relationship dynamics, including family, roommates, children, pets, etc. _____

EMERGENCY CONTACT

In Case of Emergency, please contact: Name: _____

Home Phone: _____ Mobile Phone _____ Work Phone _____

EDUCATION, EMPLOYMENT & MILITARY STATUS

Are you currently a student? ○ Yes ○ No

If so, what year? _____ Major/Focus: _____ GPA: _____

Are you currently employed? ○ Yes ○ No

Profession: _____ Job Title: _____

Company: _____

Military Service? ○ Yes ○ No Current Status: ○ Active ○ Reserve ○ Retired ○ Guard ○ Other

OTHER INFORMATION

How did you find Center for Self Balance? _____

May I thank a person/agency for a referral to me? ○ Yes ○ No Referred by: _____

Best time for sessions: ○ Morning ○ Afternoon ○ Evening

Time zone (for phone clients only): ○ EST ○ CST ○ MST ○ PST ○ Other _____

REASON FOR YOUR VISIT

Please list your reasons for being here now – current life issues, etc. _____

_____

_____

_____

_____

CURRENT ISSUES (check all that apply)

Depression/Mania

___feeling sad/alone
___loss of interest/pleasure in most activities
___poor grooming
___change of weight (>5%)
___fatigue or loss of energy
___feelings of worthlessness
___inappropriate or excessive guilt
___inflated self-esteem
___decreased need for sleep
___more talkative than usual
___flight of ideas/distractibility
___excessive activity (work, social, spending, sexual)

Suicidal Thoughts

___feelings of hopelessness
___suicide attempt (past/current)
___suicidal/homicidal thoughts (past/current)
___recurrent thoughts of death
___family/other history of suicide

Mood

___argue a lot
___anger, lose temper easily
___uptight, can't relax
___easily irritated
___grief/any loss
___crying a lot/extreme mood swings
___emotional overreaction
___change in personality

Relationship Issues

___difficulty making friends
___difficult relationships with others
___chooses solitary activities
___family issues/conflict
___spiritual issues/conflict

Anxiety

___intense fear or discomfort
___rapid heartbeats/chest pain
___feeling of choking/dizzy/lightheaded
___feelings of unreality
___detached from self
___fear of losing control/dying?
___worry about panic attacks
___avoiding places/situations
___obsessive thoughts
___repetitive behaviors-used to reduce stress?
___distressing recall of traumatic event/s
___can't control worry

Personality Traits

___disturbing/violent thoughts
___deceitfulness
___aggression towards self or others
___destroying things
___feeling indifferent or disagreeable
___unstable self-image
___self-mutilation
___chronic feelings of emptiness
___paranoid behavior
___sexually seductive
___overly dramatic
___constant need for approval
___must be center of attention
___feeling entitled/superior
___envious of others
___fear of rejection
___afraid of social situations
___difficulty making decisions
___problems being assertive
___sexual promiscuity

Substance Use

___drinking too much
___taking too many drugs

Cognition and Communication

___racing thoughts
___obsessions
___slowness of thinking
___unusual thoughts
___intrusive memories or "flashbacks"
___problems with reading
___problems with memory
___decreased clarity of thought
___difficulty organizing
___difficulty meeting deadlines

Somatic Symptoms

___extreme exhaustion
___sleep problems
___sleeping too much
___not sleeping enough
___nightmares/sleepwalking
___increase in appetite
___loss of appetite
___stomach aches/nausea
___constipation/diarrhea
___self-starvation
___binging/purging
___bed wetting
___pain
___loss of sexual desire
___inability to have sex
___impaired sexual functioning

Describe any other issues:

_____

_____

List any relevant previous treatment methods used – assess their effectiveness/your response(s): _____

_____

_____

_____

SERVICES DESIRED

Please indicate what services you desire from Center for Self Balance:

_____ Stress & lifestyle management skill-building
_____ Meditation coaching, practice & classes
_____ Help with relationships (work or personal)
_____ Career and work coaching
_____ Leadership skill building
_____ Depth psychotherapy
_____ Couples / relationship therapy
_____ Help with Trauma / PTSD
_____ Help with anxiety
_____ Help with depression
_____ Help with personal / spiritual issues
_____ Life Balance coaching
_____ Help with life transitions
_____ Emotional Intelligence coaching
_____ Hypnosis/Neuro-Linguistic Programming (NLP) / EFT
_____ Other / Unknown: _____

PSYCHOLOGICAL & MEDICAL HISTORY

Completing the following questions as fully as possible will allow for the development of a plan best suited to your specific needs

PSYCHOLOGICAL HISTORY

In the past, I have sought services for:

○ Addiction(s) ○ Mood ○ Eating /Immune System Issues ○ Other: _____

If yes to any of the above, please indicate:

Nature of issue: _____

City: _____ Date: _____

Frequency of service/# of visits: _____ Length of service_____

Name/Degree of practitioner: _____

Problem/Diagnosis: _____

Treatment: _____

What was treatment outcome? _____

May we coordinate services with him/her? ○ Yes ○ No If so, phone number: _____

MEDICAL HISTORY

Please explain any current medical concerns, (injuries, illnesses, surgeries, other disabilities, prior diagnosis of physical limitations/impairments, prior abnormal test results, etc.) _____

_____

Please list current medications/nutritional/vitamin/herbal supplements currently taken:

Type _____ Dosage/frequency taken_____ Taken for how Long? _____

Adverse reaction (If any) _____

LEGAL HISTORY

Are there any relevant legal problems at this time? If so, describe: _____

_____

DEVELOPMENTAL HISTORY

Describe overall experience with parents/caretakers growing up as a child: _____

_____

_____

Are you adopted? ○ Yes ○ No If yes, your age at the time of adoption: _____

Did you have any difficulties in childhood relevant to your concerns? If so, describe: _____

_____

_____

FAMILY & SIGNIFICANT RELATIONSHIPS

List immediate family members, including your parent(s), sibling(s), partner(s), child(ren), and any special information you would like to share (health issues, conflict, etc.)

Name / Relationship	Gender	Notes / Special info	Deceased?
	M / F		Y / N
	M / F		Y / N
	M / F		Y / N
	M / F		Y / N
	M / F		Y / N

Describe your current family: _____

_____

Describe any recent changes in yourself and/or in your relationships with friends/family: _____

_____

RELATIONSHIP STATUS

I am currently: ○ Married / Committed ○ Single ○ Divorced ○ Separated ○ Living Together ○ Other

Length of relationship (now or past): _____

Describe current (or past) partner relationship: _____

_____

Are you sexually active? ○ Yes ○ No If yes, do you practice safe sex? ○ Yes ○ No ○ Not sure

EDUCATION/WORK HISTORY

Circle current status: ○ Employed ○ Unemployed

Last or current Position: _____ How long: _____

Describe recent education/type of jobs/s held: _____

Name of Assistant (if Applicable) _____

SELF INVENTORY

What has worked well for you in your life, so far? _____

_____

Describe areas in your life you would like to see work better for you. _____

_____

Describe yourself (e.g., strengths & weaknesses): _____

_____

SPIRITUALITY/RELIGION

Describe any religious/spiritual practice, and/or place of attendance (church/ Synagogue/ Temple/ Mosque), Prayer/meditation etc. _____

What role does spirituality play in your life? _____

INTERESTS/ACTIVITIES

List your favorite recreational activities/Hobbies/Special talents or skills: _____

_____

Organizations/Groups to which you belong: _____

ADDITIONAL INFORMATION

Please feel free to add any other information, concerns or thoughts: _____

_____

AGREEMENT

Most people report significant progress on their goals from working with a coach/counselor, however there are no guarantees on outcomes. Nevertheless, each party agrees to indemnify, defend, and hold harmless the other party and its agents, officers, and employees from and against any and all liability, expense, including defense costs and legal fees incurred in connection with claims for damages of any nature whatsoever including but not limited to, bodily injury, death, personal injury, financial or business losses, or property damage arising from such party's performance or failure to perform in obligations. *Pre-paid discounts and Phone/Skype session(s) fees are pre-paid via check/money order (snail-mail) or online payment (see link on website). Once payment is confirmed sessions can be scheduled. *For In-office sessions, please pay prior to session if paying online – or pay cash/check at the time of session. We can provide an invoice or insurance codes for counseling services if requested.

I agree I'm responsible for my actions – by signing this, agree to these terms: barring emergency I'll give a min. 48-hrs notice if I need to re-schedule. Joseph has my permission to share elements of my story (w/out identifying details of who I am without written permission)

_____ _____/_____/_____

Client Signature Date