CHICO CENTER FOR
COGNITIVE
BEHAVIOR
THERAPY

JOEL MINDEN, PhD
CA LICENSE: PSY27859

NEW CLIENT INFORMATION FORM

Name: _____ I prefer to be called: _____
Parent/guardian: _____ Today's date: _____
Date of birth: _____ Age: _____
Sex/Gender: _____ Sexual orientation: _____
Occupation: _____ Employer: _____
School: _____ Level of education: _____
Race/Ethnicity: _____ Religion/Spiritual practice: _____

Home address: _____ OK to contact by mail? ☐ Yes ☐ No
Home phone: _____ OK to leave message? ☐ Yes ☐ No
Cell phone: _____ OK to leave message? ☐ Yes ☐ No
Work phone: _____ OK to leave message? ☐ Yes ☐ No
E-mail: _____ OK to e-mail you? ☐ Yes ☐ No
(Please note: E-mail correspondence is not considered to be a confidential method of communication)

Marital status: _____ Partner/spouse's name: _____
Children: ☐ Yes ☐ No Ages of children: _____
Emergency contact: _____ Relationship/phone: _____

Current physician: _____ Phone: _____
Current medications: _____ Purpose: _____

Do you have any serious or chronic medical conditions (including past surgeries)? ☐ Yes ☐ No
If yes, date(s) and details:

Current and previous psychological or psychiatric treatment (psychotherapy, psychiatric medications):

Provider name: _____ Services/Dates: _____ Phone: _____
Provider name: _____ Services/Dates: _____ Phone: _____
Provider name: _____ Services/Dates: _____ Phone: _____
Provider name: _____ Services/Dates: _____ Phone: _____

How did you hear about this practice?

What is the main reason you're seeking therapy?

How long have you had these problems or symptoms? How often do they occur?

Are there certain events that seem to trigger these symptoms?

List the people, activities, groups, and hobbies that are supportive to you:

What are your goals for treatment?

Which treatments or lifestyle changes have you tried already?

Below is a list of common challenges people face. Please check any that currently apply to you.

Anxiety

☐ Generalized anxiety ☐ Specific fears/phobias ☐ Panic attacks ☐ Social anxiety

☐ Obsessive thinking ☐ Compulsive behaviors

Mood

☐ Sadness or depression ☐ Anger or irritability ☐ Loss of pleasure in life ☐ Frequent crying

☐ Mania ☐ Loss of energy ☐ Emotionally overwhelmed ☐ Thoughts of suicide ☐ Mood swings

Behaviors

☐ Self-harm behavior ☐ Problems with eating ☐ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.).

Sleep

☐ Problems falling asleep ☐ Trouble waking up ☐ Fatigue/tiredness during the day

☐ Problems sleeping through the night ☐ Nightmares

Cognitive

☐ Problems with attention or concentration ☐ Racing thoughts ☐ Paranoia ☐ Memory problems

Interpersonal

☐ Problems making or keeping relationships ☐ Relationship/marriage problems ☐ Problems with intimacy ☐ Sexual problems ☐ Shyness ☐ Family problems ☐ Recent breakup/Separation/Divorce ☐ Difficulties with assertiveness

Identity

☐ Sexuality ☐ Self-esteem ☐ Sense of self ☐ Cultural concerns ☐ Career choices ☐ Personal values ☐ Body image concerns

Other

☐ History of abuse (emotional, physical, sexual) ☐ Problems with job/school Problems with alcohol or drugs ☐ Financial problems ☐ Legal situation ☐ Grief or loss ☐ Traumatic experience ☐ Medical problems ☐ Racism/discrimination ☐ Other

Substance Use

Have you ever used any of the following substances?

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Hallucinogens (LSD) ☐ Heroin ☐ Methamphetamines ☐ Cocaine ☐ Stimulants (Pills) ☐ Ecstasy ☐ Methadone ☐ Tranquilizers ☐ Pain killers

If yes to any, list frequency and dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?

Do you smoke cigarettes? If yes, how many per day?

Do you drink caffeinated beverages? If yes, how much per day?

Have you ever abused prescription drugs? If yes, which ones?

Is there anything else you would like to share or indicate prior to our first session?