

# CONFIDENTIAL NEW CLIENT INFORMATION

**TRACY G. BELL, MA, LMHC**  
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Licensed Mental Health Counselor  
License # LH 60200557

**Welcome to my psychotherapy practice. I appreciate that you have chosen to work with me to explore your counseling needs and objectives. The following information will help me to get a general idea of your circumstances. Please be as accurate as possible.**

**Today's Date:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Client's Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_

**Email address:** \_\_\_\_\_

**Marital Status:**  Single  
 Married  
 Partnered  
not married  
 Separated  
 Divorced  
 Widowed  
 Other

**Phone Numbers**      **Home:** \_\_\_\_\_      **Cell:** \_\_\_\_\_

**Age:** \_\_\_\_\_      **Birth date:** \_\_\_\_\_

**Names of others who live in your household, including pets:**      **Age:**      **Relationship:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list any children you have who do not live with you:**

<b>Name</b>	<b>Age if living</b>	<b>Living where</b>	<b>Deceased when</b>
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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**Occupation** (if retired or not working, please state what occupies your time and energy):

\_\_\_\_\_

**Employer (if applicable):** \_\_\_\_\_ **Self-Employed:** \_\_\_\_\_

**Education** # of years: \_\_\_\_\_ Degree: \_\_\_\_\_

Field of education: \_\_\_\_\_

**Family of Origin:**

Name	Age if living	Living where	Deceased when
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Siblings (in birth order, including yourself)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In your family, was there a history of:  Alcoholism  Substance abuse  Mental Illness  
 Physical or sexual abuse

**Health:**

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Significant Medical Problems:

\_\_\_\_\_  
\_\_\_\_\_

Have you had previous counseling or psychiatric care?  Yes  No

If yes, please give:  
Name of clinician Degree/License Time period from to  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or other psychiatric issues?

Yes  No Specifics: \_\_\_\_\_