

NEW CLIENT INFORMATION

Previous Treatment

List previous mental health and/or chemical dependency treatment (including alcohol or drug) you have received:

Provider/Agency	Dates	Reason	Outcome

Family History List any medical and mental health conditions of family members:

Medical:

Family Member	Condition	Dates

Mental Health/Substance Abuse:

Family Member	Condition	Dates

Substance Use History (Please complete if client is 12 years or older)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamine					
Cocaine					
Hallucinogens					
Others					

Legal History

Describe any pending or post-legal matters (including Visitation/Custody):

This information is accurate to the best of my knowledge.

Signature of Client

Guardian (if necessary)