LUBA OLMSTEAD NPD * www.lubaolmstead.com * luba.olm@gmail.com * **(786)553-2500**

NEW CLIENT FORM

Please fill out this form prior to your first paid session, where we will explore the problems you have indicated in more depth. Please note:The information you provide here is protected as confidential information. (READ LIMITS OF CONFIDENTIALITY, ALL YOUR ANSWERS ARE KEPT STRICTLY SECURE AND ARE NOT DISCLOSED TO ANYONE WITHOUT YOUR CONSENT)

Name: _____Date of birth: ____ /____ /____ Age:___
Gender:_____Address:_____
_____ (Street) (City) (State) (Zip)

Cell Phone: ( ) _____ Is it okay to leave a voicemail? □ Yes □ No Is it okay to text you? □ Yes □ No

E-mail: _____ *Please note: Email correspondence is not considered to be a confidential medium of communication. Name of parent(s)/guardian(s) (if under 18 years):

_____
(Primary Parent/Guardian) (Address) (Phone)

Emergency contact:

_____
(Name) (Relationship) (Phone)

Marital Status: □ Single/ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

If using sliding scale option please list all others living in the home and their ages:

_____
_____

How did you find out about Luba OLM NPD?

_____

By signing below, I agree and consent to mental health sessions with or without naturopathy recommendations from Luba OLM NPD

_____
(Client signature) (Date)

_____

(Parent/Guardian signature) (Date)

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, treatment program, group, etc.)? □ No □ Yes Please list previous therapist(s)/ mental health services(s):

   _____
   ___
   _____

2. Have you ever been prescribed psychiatric medication in the past? □ No □ Yes; Please list:

   _____
   _____

3. Are you currently taking any prescription medication? □ No □ Yes; Please list:

   _____
   _____

4. How would you rate your current physical health? (please circle) *Poor, Unsatisfactory, Satisfactory, Good, Very good.* Please list any specific health problems you are currently experiencing:

   _____
   _____

5. How would you rate your current sleeping habits? (please circle) *Poor, Unsatisfactory, Satisfactory, Good, Very good.* Please list any specific sleep problems you are currently experiencing:

   _____
   _____

6. How many times per week do you generally exercise? _____ What types of exercise/ physical activity do you participate in?

   _____
   _____

7. Please list any difficulties you experience with your appetite or eating patterns:

   _____
   _____

8. Are you currently experiencing any pain? □ No □ Yes If yes, please describe:

_____
_____

9. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes If yes, when did you begin experiencing this?
   _____

_____
On a scale from 1-10, how severe is your anxiety when it is at its worst? _____

10. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes If yes, for approximately how long?

_____
_____

Have you ever experienced any suicidal thoughts? □ No □ Yes

Have you experienced any suicidal thoughts in the past three months? □ No □ Yes

Have you ever engaged in self-harm behavior? □ No □ Yes

Have you engaged in self-harm behavior in the past three months? □ No □ Yes

Have you been hospitalized for suicidal thoughts, attempts, self-harm behavior? □ No □ Yes If yes, when, and how long was your hospital stay(s)?

_____
_____

11. Do you currently drink alcohol? □ No □ Yes
If yes, how frequently do you drink, on average, and how much alcohol do you drink in one sitting, on average?

_____

12. Do you currently use any chemical drugs or pills for recreational purposes except marijuana (prescribed or not): □ No □ Yes If yes, please list how much and what type:

_____

13. Do you currently use any CBD or marijuana products? □ No □ Yes If yes, please list how much and method of a use:

_____

14. Do you currently use or used in the past any natural or chemical psychedelics (Buffo Alvarus, 5-MeO-DMT, Ayahuasca, Shrooms, Ibogaine, Acid and alike substances) □ No □ Yes If yes, please collaborate on the experience(s):

_____
_____

15. Have you used alcohol or any chemical or natural drugs in the PAST? (including experimental use)? □ Never □ Yes If yes, please list how much and what type:

_____
_____

16. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____ On a scale of 1-10, how would you rate your satisfaction with your relationship? _____ Please list any problems you are experiencing in your relationship:

_____
_____

17. Have you ever experienced any form of abuse or neglect in childhood or adulthood? This can include physical abuse, any type of unwanted sexual contact, or domestic violence. □ No □ Yes If yes, please explain:

_____
_____

18. What significant life changes or stressful events have you experienced recently?

_____
_____

19. Are you suffering from PTSD (Post Traumatic Stress Disorder) □ No □ Yes If yes, please explain if cause is known?

_____
_____

20. Are you currently employed? □ No □ Yes If yes, do you enjoy your work? _____ Is there anything stressful about your current work?

_____
_____

21. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:_____
__

22. What do you consider to be some of your strengths and weaknesses?

_____

23. What do you consider to be some of your weakness?

_____

24. What would you like to accomplish out of your time in therapy?

_____

25. Is there any other information you would like to share that is relevant to you as a person, the problems you are experiencing, or to past history?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.). Please Circle List Family Member(s), if applicable:

Alcohol/Substance Abuse yes/no _____
Anxiety yes/no_____
Depression yes/no_____
ADHD/ ADD yes/no_____
Eating Disorders yes/no _____
Bipolar Disorder yes/no _____
Obsessive Compulsive Behavior yes/no _____
Delusions/ Hallucinations yes/no _____
Suicide Attempts yes/no _____
Personality Disorders yes/no _____