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: ()it okay to text you?	Is it okay to leave a voicemail? □ Yes □ No Is □ Yes □ No
E-mail:	*Please note: Email
correspondence is r	not considered to be a confidential medium of communication. Name of s) (if under 18 years):
(Primary Parent/Gua	ardian) (Address) (Phone)
Emergency contact:	
(Name) (Relationsh	ip) (Phone)
Marital Status: □ Sir Divorced □ Widowe	ngle/ Never Married □ Domestic Partnership □ Married □ Separated □ d
If using sliding scale	e option please list all others living in the home and their ages:
How did you find ou	t about Luba OLM NPD?
	agree and consent to mental health sessions with or without naturopathy rom Luba OLM NPD
(Client signature) (D	Pate)

(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.)? \square No \square 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) <i>Poor, Unsatisfactory, Satisfactory, Good, Very good.</i> Please list any specific health problems you are currently experiencing:		
5.	How would you rate your current sleeping habits? (please circle) <i>Poor, Unsatisfactory,</i> 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?
Or	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?
— Ha	ve you ever experienced any suicidal thoughts? □ No □ Yes
Ha	ve you experienced any suicidal thoughts in the past three months? \square No \square Yes
Ha	ve you ever engaged in self-harm behavior? □ No □ Yes
Ha	ve you engaged in self-harm behavior in the past three months? □ No □ Yes
	eve you been hospitalized for suicidal thoughts, attempts, self-harm behavior? No Yes If s, when, and how long was your hospital stay(s)?
lf y	. Do you currently drink alcohol? □ No □ Yes ves, how frequently do you drink, on average, and how much alcohol do you drink in one ting, 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? 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? there anything stressful about your current work?
21. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith of 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 persor problems you are experiencing, or to past history?	1, the
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 Obassiya Campulaiya Bahayiar yas/as	
Obsessive Compulsive Behavior yes/no	
Delusions/ Hallucinations yes/noSuicide Attempts yes/no	
Personality Disorders yes/no	