Good Help Clinic
3606 So. 5th St.
Temple, Texas 76502
254-295-1742

New Client Information

PLEASE PRINT LEGIBLY

Date: _____

Name _____

Address _____

_____

_____

Telephone # _____

Date of Birth _____

Email address _____

How did you hear about Good Help Clinic? _____

Do you wish to use health insurance to cover the cost of treatment? _____
If so, please give your insurance information:

Insurance Carrier: _____

Social Security Number: _____

PLEASE COMPLETE ADDITIONAL PAGES

What brings you to this Mental Health Clinic Today? _____

How long has this been a problem for you? _____

Personal Hx: Sexual Orientation: _____ Married? ___ How long? ____ Who do you live with? _____

Ages of all children living with you: _____ Ages of deceased children: _____

Number of previous marriages: _____ Ages of children not living with you _____

Education: _____ Current Occupation: _____ Currently Employed: _____ How long: _____

Leisure Activities: _____ How many friends do you have? _____

Psych Hx

Have you ever been admitted into a psychiatric hospital? _____ If so, please explain: _____

Have you ever seen someone regarding your mental health? _____ If so, please explain: _____

Are you currently taking psychiatric medications? _____ If so, which ones? _____

_____

Have you ever in the past taken psychiatric medications? _____ If so, which ones? _____

Have you ever attempted suicide? _____ If so, how many times? ____ Please explain: _____

Has anyone in your family ever suffered from mental illness? _____ If so, please explain: _____

Trauma Hx

Were you physically abused as a child? ____ Sexually abused? _____ Emotionally abused? _____

Have you ever been physically assaulted as an adult? ____ Sexually assaulted? _____ Emotionally abused? _____

Legal Hx

Have you ever been convicted of a crime? ____ If so, please briefly describe: _____

How many times have you been arrested? _____ If so, for what? _____

Have you ever served time in prison? ____

Sub Abuse Hx

Do you drink alcohol? _____ If so, how much per day? _____

Have you had alcohol problems in the past? ____ Have you ever been charged with DUI/DWI? _____

Do you use any drugs? _____ If so, what, and how often? _____

Have you had drug problems in the past? _____ If so, please explain: _____

Military Hx

Branch of Service: _____ Date(s): _____

Military Occupation: _____ Rank at discharge: _____ Type of Discharge: _____

Combat experience? _____ If yes, where & when? _____

Below is a grid of problems that people often have. Each box contains one item. As you read each item carefully, please indicate your present level of concern for that item by placing the appropriate number in the box. **Numbers should range from 0-5 where 0 = no concern, and 5= very high concern.** Also in the box, put the approximate date that the problem started. Please answer questions as honestly as possible.

___ Internal conflict or confusion	___ Nervous around people	___ Worried about a family member	___ Thinking about same thing over & over	___ Concerned about alcohol or drug use	___ Others are concerned about my alcohol or drug use	___ Habits interfere with daily activities
___ Lack of life goals and purpose	___ Unable to forget past mistakes	___ Having very unusual experiences	___ Concern about physical appearance	___ Memory problems	___ No one to talk to	___ Low self-esteem
___ Physical abuse or assault	___ Family conflict	___ Health problems	___ Fear of insanity	___ Unlovable	___ Difficulty speaking up	___ Fatigue
___ Sexual assault or abuse	___ Feelings of fear or panic	___ Church attendance	___ Unhappy too often	___ Loneliness	___ Racing thoughts	___ Thoughts of hurting or killing someone
___ Mood swings	___ Problems sleeping	___ Poor eating habits	___ Lack of exercise	___ Good relationship w/GOD	___ Feeling like you don't fit in	___ Guilt
___ Feeling left out of things	___ Financial problems	___ Problems at work	___ Distrust of others	___ Difficulty coping	___ Disappointed with yourself	___ Legal problems
___ Conflict in relationship	___ Being laughed at or criticized	___ Difficulty reaching goals	___ Feeling like things are not real	___ Want to die	___ Lack of self control	___ Too busy
___ Feelings of failure	___ Difficulty with children	___ Feeling hopeless	___ Boredom	___ Recent difficult changes	___ Problem with body weight	___ Feeling out of control
___ Discrimination or harassment	___ Sexual concerns	___ Conflict with others	___ Death	___ Anger	___ Stupid People	___ Emotional abuse
___ Difficulty concentrating	___ Pain	___ Nightmares	___ Hear or see things other people don't hear or see	___ Crying	____ Need to be perfect	____ Unable to relax