



Mindful Healing Counseling Services, LLC
Deborah Emery-Gigliotti, LCMHC
100 Shattuck Way
Newington, NH 03801
603-431-6677
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New Patient Information Sheet

Name _____ Date _____

DOB _____ SSN _____ Telephone _____

Mailing Address _____

Physical Address _____

Referred by _____ Referred to _____

Emergency Contact _____ Telephone _____

Presenting Problem _____

Client's Attitude Towards Treatment _____

Prior Treatment (hospital/outpatient) _____

Current Medications _____

Special Needs: _____

How is Current Problem affecting your daily living? _____

Prior Therapist(s) _____

Family Information

Name _____ DOB _____ Age _____

Spouse/Partner's Name _____ Age _____ Illnesses _____ Year Deceased _____

Mother's Name _____ Age _____ Illnesses _____ Year Deceased _____

Father's Name _____ Age _____ Illnesses _____ Year Deceased _____

Sibling's Name _____ Age _____ Illnesses _____ Year Deceased _____

Sibling's Name _____ Age _____ Illnesses _____ Year Deceased _____

Sibling's Name _____ Age _____ Illnesses _____ Year Deceased _____

Sibling's Name _____ Age _____ Illnesses _____ Year Deceased _____

Children's Name _____ Age _____ Illnesses _____ Year Deceased _____

Children's Name _____ Age _____ Illnesses _____ Year Deceased _____

Have you had any experiences of major losses/deaths in your life that have particularly hard? If yes, please explain;

Education/Employment History

Degree(s) Earned _____

Any learning difficulties in school? If yes, please explain _____

Any history of hyperactivity or behavioral problems in school? If yes, please explain _____

Employment History (last 3 years) _____

Medical History

Present Physician _____

Date of Last Physical _____

Previously Diagnosed Medical Conditions _____

Year _____ Condition _____ Doctor _____

Treatment _____

Any history of head injury? If yes, explain _____

Allergies _____

Prescription drugs currently taking _____

Prescription drugs taken in the past _____

Prior psychiatric treatment _____

Date _____ Doctor _____ Diagnosis _____

General Health History: Check all that apply to you or that are present in your family.

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mobility Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Brain Injuries | <input type="checkbox"/> Chronic Pain |

Eating Regularly? _____ If no, explain _____

Any Binging/Purging? _____

What are your exercise habits? _____

What are you sleeping habits? _____

Any Nightmares? _____ If yes, explain _____

Legal History

Have you ever been arrested? ____ If yes, explain _____

Are there currently any restraining orders against you? _____

Have you ever been incarcerated? ____ If yes, explain _____

Are you on probation/parole? _____

Please list probation officer's name and contact information _____

Military Information

Branch _____ Rank _____ Service Dates _____

Type of Discharge _____ Legal/Medical Problems _____

Were you exposed to combat situations? ____ If yes, explain _____

Leisure Time/Hobbies

What do you enjoy for hobbies? _____

What do you do to relax? _____

History of Substance Use

	Frequency	Duration	Method
<input type="checkbox"/> Caffeine			
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Cannabis			
<input type="checkbox"/> Prescription Medication			
<input type="checkbox"/> Cocaine			
<input type="checkbox"/> Nicotine			
<input type="checkbox"/> Crack			
<input type="checkbox"/> Stimulants			
<input type="checkbox"/> Inhalants			
<input type="checkbox"/> Heroin			
<input type="checkbox"/> Hallucinogens			
<input type="checkbox"/> Other			

Any history of trying to quit any substance? _____ if yes, explain _____

Have you ever entered into a rehabilitation facility? _____ If yes, explain _____



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Telephone Contact Permission Form

Yes/No -- In the event of a cancellation or rescheduling of an appointment, I give my permission to Deborah Emery-Gigliotti, LCMHC of Mindful Healing Counseling Services to contact and leave a message with the below named individual.

Contact Person's Name _____

Relationship to Client _____

Telephone Number _____

Yes/No -- I also give my permission for a message to be left at this phone number on the answering machine.

Client's Signature _____ Date _____

Witness _____ Date _____

Yes/No -- I give my permission for a message to be sent to me via email at the following email address(es).

Email Address _____

Client Signature _____ Date _____

Witness _____ Date _____