Marina Lombardo, LCSW, PA

1151 Blackwood Avenue, Suite 120

Ocoee, FL 34761

(407) 615-0848 Office (407) 578 9922

www.marinalombardo.com

New Client History Form

Today's Date: _____

Name _____Date of Birth_____ Age_____

Current Address _____

Do you rent or own? _____ How long have you been at this address?_____

Employer: _____ Position: _____ How long have you worked there? _____

Home Phone _____Cell Phone _____Work Phone _____

Email address: _____

Marital Status: Single/Divorced/Widowed/Married _____ years

Number of Children: _____ Ages: _____

Others Living in the Home

Name Relationship to You Age

Current and Previous Treatment (Counseling/Mental Health/Substance Abuse)

Date(s) Provider Helpful/Not Helpful

Education

School Dates Performance/Difficulties/Graduated

Prior Employment

Employer Dates of Employment Reason for Leaving

Military Service

Branch/Dates Age Position Stationed at

Legal Problems

Past:

Present:

Medical

Past illnesses, injuries, etc.:

Date Physician/Caregiver Treatment Helpful/Not helpful

Date of last doctor visit:

Current Health Conditions/Concerns:

Current Medications:

Any problematic side effects with any medication?

If yes, explain:

Drug Use

Substance:	First Time	Last time	How much	How Often	Problems?
Hard Liquor					
Beer/wine					
Marijuana					
Other recreational drugs					
Caffeine					
Tobacco					
Other					

Do you have concerns/or has anyone ever expressed concern over your use of: (circle any that apply)

Pornography Spending Thrifting Video games Exercise Sexuality

Other _____

Sexuality

Would you describe yourself as: (circle)

Heterosexual Homosexual Bisexual Bicurious

Eating

Typical Pattern: _____times daily Appetite: ____Poor ____Good _____Excessive

Nutritional Quality of what you eat: _____Poor _____Good _____Excellent

Any problems with food now or in the past?

Weight change? _____Gained _____Lost _____pounds over _____(time period)

Sleeping

Typical Pattern: To sleep at ____(time) Awake at ____(time) Alarm? _____

Time it takes to get to sleep?_____ Quality of sleep? _____

Number of times you awaken: ____Time it takes to get back to sleep: _____

What helps? _____

Dreams: (circle) Pleasant Unpleasant Distressing Recurrent Absent

Cause you to awaken

Activities

Amount of time spent per week working: _____ Family/home care: _____

What do you do in your spare time? _____

Number and type of social contacts per week: _____

Support

Who do you spend time with: _____

Who do you talk with about concerns: _____

What helps to cope with problems: _____

Religious faith/spirituality: _____

Do you have a practice/attending services? _____

Is this helpful? Explain _____

Strengths/Abilities:

Reasons (s) for seeking treatment now:

Any additional information that you think would be helpful?

Anything that I didn't ask that you think is important for me to know?

WHAT YOU WOULD MOST LIKE TO CHANGE

1. What would you ideally like to see yourself successfully creating, achieving, accomplishing at this point in your life right now?

2. What would you like to be able to *do* that you feel like you *can't* do now?

3. What would you like to *stop* doing that you *are* doing now?

4. What else would you like to be able to do differently, do better, or do more effectively?

5. Assuming it was real & genuine, not just a "put on," how would you like to be acting and behaving on a moment-by-moment basis?

6. How would you like to be relating to & interacting with other people [or any particular person(s)]?

7. What personality traits would you like to develop?

8. How would you like to be feeling physically?

9. How would you like to be feeling emotionally?