Rebel Rise Counseling, PLLC
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NEW CLIENT

Please know any information provided is confidential and held in a secure location.

Welcome. I understand this step can be difficult. Please fill out the following with as much detail as you are comfortable providing. You may choose to leave information blank.
See you soon!

Contact Information

Date: ____________________

Name: ____ Birthday: ____ /____ /_______

Address: ____ Unit Number: ______________

City | State | Zip: _______________________ | _______________________ | ________________

Phone: (______) _______ – __________ Is it safe to leave detailed messages? ☐ Yes ☐ No

Email: ____________________________ Is it safe to leave detailed messages? ☐ Yes ☐ No

What is your preferred method of communication? ○ Phone ○ Text ○ Email

Name of Emergency Contact: ___________________________ Relationship: ________________

Emergency Contact Phone Number: (______) _______ – __________

Background

How did you hear about Rebel Rise Counseling? ______________________________

Have you had prior counseling experience? ☐ Yes ☐ No

Relationship Status: (e.g. Single, Partnered, Polyamorous, married, separated, divorced, widowed, other): ______________________________

Employment Status: (e.g. Unemployed, Part-Time, Full-Time, Retired, Self- Employed):

____

Company/School Name: ______________________________

Identification

How do you identify in terms of race/ethnicity/culture? ______________________________

____

How do you identify in terms of spirituality/religion? ______________________________

____

How you identity in terms of gender? ______________________________

____

How do you identity in terms of sexuality? ______________________________

____

Medical History

Do you have a primary care doctor? ☐ Yes ☐ No

Name: ______________________ Phone: (____) _____ – ______

Office/Organization: ______________________________

Do you have a psychiatrist? ☐ Yes ☐ No

Name: ______________________ Phone: (____) _____ – ______

Office/Organization: ______________________________

Do you have another healthcare provider? (i.e. acupuncturist, massage therapist, nutritionist, body energy worker, chiropractor, etc.)

1. Name: ______________________ Phone: (____) _____ – ______

   Office/Organization: ______________________________

2. Name: ______________________ Phone: (____) _____ – ______

   Office/Organization: ______________________________

** Please fill out the *Release of Information Form* if you would like me to contact any of your care providers regarding your health and wellness information, treatment, and/or history.

Medical History Continued

Have you ever attempted suicide(s)? ☐ Yes ☐ No

If yes, please indicate when: ______________________________

Previously diagnosed conditions: ______________________________

____

Health concerns: ______________________________

____

Current medications, vitamins, or supplements you are taking: ______________________________

____

Past hospitalizations or inpatient treatments: ______________________________

____

Physical, emotional, or relational traumas/abuse: ______________________________

____

Personal Information

Why did you decide to seek counseling now? ______________________________

____

What are your goals or desired outcomes for seeking therapy at this time? ______________________________

____

What are your hobbies or sources of joy? ______________________________

____

What areas or aspects in your life create stress? ______________________________

____

Do you have any questions for me? ______________________________

____

Is there anything else you would like me to know about you? ______________________________

____

Thank you for your time.
I look forward to our work together!