infinite
healing & wellness

2563 S. Val Vista Dr., Suite 108
Gilbert, AZ, 85295
(480)448-1076
info@infinitehw.com

New Client Information

Full Name			**Date**
Street Address	**City**	**State**	**Zip Code**
Home Phone	**Work Phone**	**Cell Phone**	
***Social Security Number**	**Birth Date**	**Age**	
Race and/or Ethnicity	**Sexual Orientation**	**Gender**	**Religious Affiliation**
Email	**Highest Level of Education Attained**		
Employer (if employed)	**Job Title (if employed)**		
Relationship Status	**In case of emergency, please notify (provide name and phone #):**		

Please provide the following health information.

Primary Care Doctor	**Primary Care Doctor's Phone #**
List Any Current Medical Problems	
How much do you usually smoke?	**How much alcohol do you usually drink?**
How much caffeine do you drink per day?	**Do you take vitamins and/or herbal supplements?** **Yes No**
How often do you get 20 minutes or more of exercise?	**Do you regularly practice relaxation techniques (e.g., meditation, yoga)?** **Yes No**

How did you find Infinite Healing & Wellness? (Doctor referral, friend, internet, etc.) _____

_____

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Current Concerns

Below is a list of commonly experienced concerns. To facilitate the best assessment of your current situation, please circle the number indicating the degree to which each item is presently a concern for you using the following scale:

Not at all	Mildly	Moderately	Quite a bit	Very much
0	1	2	3	4

1. Dealing with stress or pressure		2. Someone else's habits or behaviors	
3. Adjusting to a new work or living environment		4. Unwanted/out-of-control behaviors or habits	
5. Feeling depressed, sad or down		6. Problems with assertiveness or shyness	
7. Establishing a career direction		8. Sleep problems	
9. Death or illness of a significant person		10. Rape, sexual assault or sexual harassment	
11. Performance anxiety, work or academic progress		12. Eating problems (bingeing, restricting, low appetite, vomiting, laxative use, etc.)	
13. Time management		14. Relationships with romantic partner/spouse	
15. Difficulties related to sexual identity or sexual orientation		16. Physical health problems (headache, pain, fainting, injury, fatigue, etc.)	
17. Feeling anxious, fearful, worried or panicky		18. Sexual matters (pregnancy, sexually transmitted disease, sexual functioning, etc.)	
19. Feeling unmotivated, procrastination or difficulty concentrating		20. Urge or plan to harm another person	
21. Feeling irritable, tense, angry or hostile		22. Relationships with supervisors or instructors	
23. Relationships with family members (parents, siblings, children, relatives)		24. Suicidal thoughts and feelings	
25. Money, finances		26. Racial, sexual or other discrimination	
27. Feeling lonely, isolated or uncomfortable with others		28. Feelings of guilt or self-criticism	
29. Values, beliefs, religion or spirituality		30. Weight or body image problems	
31. Past sexual experiences (sexual abuse, incest, unwanted sexual behavior)		32. Your use of alcohol, drugs or other substances	
33. Low self-esteem or self-confidence		34. Unusual perceptual experiences (hearing voices, seeing things, etc.)	
35. Legal matters		36. Other_____	

Were you adopted? **YES NO**	**Have your parents ever been divorced?** **YES NO If Yes, when?**	**Are both parents still alive?** **YES NO**
Any history of mental illness such as depression or anxiety in your family? YES NO	**Any history of suicide in your family? YES NO**	
Any family history of drug or excessive alcohol use? YES NO	**Any history of abuse in your family? YES NO**	
Have you or any members of your family had legal problems? YES NO	**Have you ever served in the military? YES NO If Yes, which branch?**	

Please describe your reasons for seeking counseling/therapy at this time:

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