Karen Crane, Psy.D. Licensed Psychologist

Adult New Client Form

Client's Name: _____ DOB: _____

Describe the problem(s) that brought you here today: _____

_____

_____

_____

Please circle any of the following problems that you feel may be troubling you:

Panic attacks/intense anxiety	guilt feelings	relationship issues
Nervousness	parenting issues	separation/divorce
Shyness	irritability	marital problems
Feeling sad	quick temper	sexual concerns
Loss of appetite	health problems	unsatisfactory job/loss of job
Appetite changes	racing thoughts	drug/alcohol use
Sleep problems	difficulty concentrating	flashbacks
Suicidal thoughts	difficulty making decisions	nightmares

☐ yes ☐ no Have you ever received mental health treatment? Please list dates of treatment, provider, and reason for treatment: _____

_____

_____

Primary Care Doctor: _____

Do you have any medical problems? Please list any CURRENT health concerns:

_____

_____

_____

Current Prescription Medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

_____ _____

Signature Date