Ting-Yi Huang, Licensed Marriage and Family Therapist 87929
New Light Counseling Service
Client Information Form

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Today's Date ______________________ New Client ☐ Yes ☐ No
First Name __________________________ Last Name __________________________ MI ___
Date of Birth (mm/dd/year) ___________________ Age _______ ☐ Check if Under 18 Years
Address _____________________________ City ______________State ___ Zip ___________
Phone (Home) ________________________ Phone (Cell) __________________________
Phone (Work) ________________________ ☐ Check if ok to leave a voice mail

Gender ☐ Male ☐ Female ☐ Trans ☐ Non-Binary
☐ Prefer Not to Answer

Marital Status ☐ Single ☐ Married ☐ Domestic Partners ☐ Separated
☐ Divorced ☐ Widowed ☐ Prefer Not to Answer

Cultural Background ☐ Black/African American ☐ Native American/Alaskan Native
☐ Middle Eastern ☐ White
☐ Asian/Southeast Asian ☐ Hispanic/Non-Hispanic Latino
☐ Multicultural ☐ Other

For Minor Receiving Services (Client Under the Age of 18 Years)

Name of Current School _________________________________ Current Grade ____________
Parent/Guardian Name (if applicable)
First Name __________________________ Last Name __________________________MI ___
Parent/Guardian Name (if different from yours)
Address _____________________________ City ______________State ___ Zip ___________
Phone (Home) _________________________ Phone (Cell) __________________________

Parent/Guardian Name (if applicable)
First Name __________________________ Last Name __________________________MI ___
Parent/Guardian Name (if different from yours)
Address _____________________________ City ______________State ___ Zip ___________
Phone (Home) _________________________ Phone (Cell) __________________________

For Couples Receiving Services (Couples Counseling Client)

Spouse/Partner Name
First Name __________________________ Last Name __________________________MI ___
Spouse/Partner Name (if different from yours or does not live together)
Address _____________________________ City ______________State ___ Zip ___________
Phone (Home) _________________________ Phone (Cell) __________________________

How long have you been dating?__________ And/or married (if applicable)? ___________

How Happy Are You In Your Marriage/Relationship?
☐ Very Happy ☐ Happy ☐ Neutral ☐ Unhappy ☐ Very Unhappy

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Emergency Contact Information

In case of an emergency, please contact:

Name________________________________ Relationship ________________

Best Contact Number ______________________ ☐ Check if ok to leave a voice mail

Please sign here if you consent for New Light Counseling Service to contact the above named individual in the event of an emergency______________________________________

Primary Care Doctor Information

First Name ________________________ Last Name ________________________MI ___

Address __________________________ City _____________State ____ Zip ___________

Phone (Work) ______________________ Date of Last Physical Check-up ______________

☐ Yes ☐ No Currently, do you have any medical conditions?
If yes, please describe ____

☐ Yes ☐ No Currently, are you taking any medication for medical conditions?
If yes, please describe ____

☐ Yes ☐ No In the past, did you have any significant medical conditions?
If yes, please describe ____

☐ Yes ☐ No In the past, did you take any medication for any significant medical conditions?
If yes, please describe ____

Please list family history of medical conditions (if applicable) ________________________

Psychiatric Service Information

Name of Current Psychiatrist (if applicable)

First Name ________________________ Last Name ________________________MI ___

Address __________________________ City _____________State ____ Zip ___________

Phone (Work) ______________________ Date of Last Appointment _________________

Psychiatrist Affiliation
- ☐ Kaiser Permanente
- ☐ Sutter Health
- ☐ San Mateo County BHRS
- ☐ Palo Alto Medical Foundation
- ☐ Private
- ☐ Other

Psychiatric Diagnosis ____

☐ Yes ☐ No Currently, are you taking any psychiatric medication such as antidepressants?
If yes, please describe ____

☐ Yes ☐ No Do your symptoms improve with the current psychiatric medications?

☐ Yes ☐ No Do you notice any side effects of the current psychiatric medications?
If yes, please describe ____

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Psychiatric Services History

Name of Previous Psychiatrist (if applicable)

First Name ____________________ Last Name ____________________ MI ___

Address ____________________ City ____________ State ___ Zip __________

Phone (Work) ____________________ Date of Last Appointment ____________________

Psychiatrist Affiliation
- ☐ Kaiser Permanente
- ☐ Sutter Health
- ☐ San Mateo County BHRS
- ☐ Palo Alto Medical Foundation
- ☐ Private
- ☐ Other

Psychiatric Diagnosis ____

☐ Yes ☐ No In the past, did you take any psychiatric medication such as antidepressants?
If yes, please describe ____

☐ Yes ☐ No Did your symptoms improve with the previous psychiatric medications?

☐ Yes ☐ No Did you notice any side effects of the previous psychiatric medications?
If yes, please describe ____

Please list family history of psychiatric conditions (if applicable) ____________________
____

Behavioral and Mental Health Services

☐ Yes ☐ No Currently, are you receiving counseling service from providers besides New Light Counseling Services?
If yes, type of counseling service
- ☐ Individual Counseling
- ☐ Couples Counseling
- ☐ Family Counseling
- ☐ Group Counseling
- ☐ Life Coaching
- ☐ Other

Name of Provider/Organization ____

☐ Yes ☐ No In the past, did you receive counseling service?
If yes, type of counseling service
- ☐ Individual Counseling
- ☐ Couples Counseling
- ☐ Family Counseling
- ☐ Group Counseling
- ☐ Life Coaching
- ☐ Other

Name of Provider/Organization ____

Risk Assessment

☐ Yes ☐ No Currently, are you thinking about hurting yourself or others?
If yes, please discuss this with New Light counselor for a personalized safety plan

☐ Yes ☐ No In the past, have you ever thought about hurting yourself or others?
If yes, how did you cope with the thought previously?

____
____

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Alcohol and Other Drugs Information

How often do you use alcohol or use recreational drugs?

☐ Not at all ☐ Once/month or less ☐ 2 or more times/week ☐ Daily

Do you think that you use alcohol to excess? ☐ Yes ☐ No ☐ Unsure

Do you think that you use drugs to excess? ☐ Yes ☐ No ☐ Unsure

Employment Information

Your Current Occupation ________________________________ Hours of Work Per Week _________

Insurance Information

Primary Insurance Carrier _______________________________ Member ID # ____________________

Subscriber Name ____ Subscriber DOB _________________

Client Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Third Party Payer Information

Name of Person Responsible for Payment to New Light Counseling Service

____

Client's Relationship to the above named third party payer

☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other

If a third party is paying for your service at the New Light Counseling Service, please sign your name below to indicate your voluntary consent to third party payer's knowledge that you are receiving services at New Light Counseling Service ________________________________

Focused Service Areas

What is your reason for seeking out for counseling services at this time? Check all that applies

☐ Anger Management ☐ Addiction ☐ Anxiety ☐ Bullying
☐ Communication Issues ☐ Couples Issues ☐ Divorce ☐ Infidelity
☐ Issues with In-Laws ☐ Family Conflict ☐ Loss and Grief ☐ Life Transitions
☐ Parenting Issues ☐ Pre-marital Counseling ☐ Psychotic Symptom
☐ Self-Esteem ☐ Trauma ☐ Others (please specify in the box below)

Is there anything else your counselor should know?

Referral Resources

How did you hear about Ting-Yi Huang/New Light Counseling Service?

☐ Word of Mouth ☐ Psychology Today ☐ Internet Research ☐ Flyer ☐ Workshop

☐ Referral by Other Providers (please specify ______________________________________)

☐ Other (please specify____)

Thank you for completing the form. Please bring the completed form to your first appointment.