HOPE THROUGH DARKNESS

# NEW CLIENT INFORMATION

## PERSONAL INFORMATION:

First Name: _____ Last Name: _____ Date of Birth: ___ /___ / ___

Gender: _____ Phone Number: _____ E-mail: _____

Living Situation: _____ Occupation: _____

## PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

**(THESE QUESTIONS WILL HELP US TO BETTER UNDERSTAND HOW OUR ORGANIZATION CAN HELP YOU)**

Have you ever been previously diagnosed with a mental health condition? **YES / NO**

- If yes, please specify: _____

Have you ever been hospitalized due to a previously diagnosed mental health condition? **YES / NO**

- If yes, please specify: _____

Are you currently taking any prescribed medications or using recreational drugs? **YES / NO**

- If yes, please specify: _____

Do you currently have thoughts of harming yourself or someone else? **YES / NO**

- If yes, please specify: _____

Do you currently have or do you have a history of any medical conditions? **YES / NO**

- If yes, please specify: _____

Briefly describe what goals you want to reach with help from Hope Through Darkness mentors?

_____

_____

_____

How did you hear about Hope Through Darkness? _____

***ALL PERSONAL INFORMATION THAT IS ENTERED ON THIS FORM, OR OTHERWISE DISCUSSED WITH ANY HOPE THROUGH DARKNESS MENTOR, IS STRICTLY CONFIDENTIAL AND ONLY TO BE SHARED WITH THE HOPE THROUGH DARKNESS ORGANIZATION TO ENSURE THE BEST POSSIBLE CARE FOR OUR CLIENTS***