

PLEASE COMPLETE FORM AND BRING IT ALONG TO YOUR FIRST APPOINTMENT

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CLIENT INFORMATION

DATE _____

Please fill out this form as completely as you can. All information is confidential unless otherwise directed by law.

Name _____ Date of Birth _____
Last First Middle

Address _____ SS # _____
Number Street
City State Zip

Home phone _____ May I contact you at this number? _____

Occupation _____ Driver's License # _____

Level of Education _____

Employer _____

Employer's Address _____
Number Street
City State Zip

Work phone _____ May I contact you at this number? _____

Please note that any communication done via mobile and landline phones, email, or fax cannot be guaranteed as confidential. By understanding the inherent risks of using these devices, you can make an informed choice about when / where / how to use those tools.

Cell phone _____ May I contact you at this number? _____

Email address _____ May I contact you here? _____

How do you prefer to be contacted? _____

In case of emergency, who would you like me to contact? _____

Please indicate relationship to you _____

Referral Information

How did you learn about my practice? _____

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HEALTH ISSUES

Who is your Physician? _____

Contact info for physician: _____

Last seen: _____ Why? _____

Serious illnesses, injuries, or surgeries: _____

Do you have any conditions / disabilities that I need to be aware of? _____

Current health concerns: _____

If you use alcohol or drugs that are not prescribed, please list how much and frequency. _____

Please list all medications that you are currently taking and why. _____

Have you ever worked with a Mental Health Professional? _____ If so, who?

Contact info for mental health professional: _____

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Last seen: _____ Why? _____

Have you ever tried to harm yourself? _____ If so, when and how? _____

Have you ever been hospitalized for mental, chemical or emotional problems? _____ If so, when? _____ Where? _____

Have you ever worked with a Coach? _____ If so, who? _____

Contact info for coach: _____

Last seen: _____ Why? _____

Other relevant information: _____

GOALS OF PSYCHOTHERAPY

Main concern? _____

How has this been a problem? _____

When did this problem first appear? _____

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What changes have you noticed recently? _____

How have you tried to solve this problem? _____

Why are you seeking help at this particular time? _____

How will you know when the problem is solved? _____

In the past, what strengths and skills have you used to assist you in making changes? They will be helpful in solving this problem. _____

Tell me about your physical health, how much you exercise, what is your diet like, and how you physically feel overall. _____

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Tell me about your spiritual / religious beliefs or what you think life is about. _____

Tell me how your mind functions and what you think about. _____

Hobbies / interests: _____

Who will benefit most from solving this problem? _____

Who might be the first to notice improvement? _____
