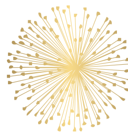

Therapy for Individuals, Couples and Families

NEW CLIENT INFORMATION

How did you hear about me?

Friend ______ Flyer ______ Good Therapy ______ Open Path Collective ______

Antioch University _____ Psychology Today ______ ICEEFT ______ Theravive ______

Seattle EFT ______

Other (please explain) ____

____

Name __________________________________ DOB ___/___/___

Age ____ Preferred Phone _______________________________________ □ CellPh □ HmPh □ WkPh

Other: ____

Email:____

Preferred Communication □Cell □ HmPh □ WkPh □ Email

Okay to leave a message on my: □ Home □Cell □ Work number □ Other

Residential Address ______________________________________ City ____________

Zip _______________

May I send mail to this address? May I use email to confirm appointments?

Employer ____

Type of Work ____

Relationship Status: Single / Engaged / Married / Partnership / Polyamorous / Monogamous / Divorced / Separated / Widowed / Other _______________________________________

How long have you been with your current partner? ______________________

How long have you been widowed or divorced? _________________________

How many children do you have? ___________________________________

How old are your children? _______________________________________

Emergency Contact ____

Relationship ____

Phone of Emergency Contact ______________________________________

What prompted you to seek therapy?

____

____

____

____

____

Who is impacted by the issue besides you?

____

Is there anything else you think would be helpful for me to know about you or your situation?

Have you had any prior counseling or psychiatric treatment?

If yes:

1. When?
2. Where?
3. Reason for and length of counseling

4. ***Check one:*** Therapy was ____ helpful ___ not helpful. Please explain:

MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician (I will not contact your doctor without your knowledge).

Date of your last physical exam

Have you been under a physician's care for any reason in the last five years? If yes, please ex

plain:

____

____

____

____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE:

Aggression____ Alcohol use____ Anger____ Anxiety_____

Chronic pain ____ Compulsive behavior ____ Concentration problems____

Cyber addiction ____ Depression ____Disorientation ____ Distractibility ____

Dizziness ____Drug dependence ____ Eating disorder ____ Fatigue ____Flashbacks ____

Grief_____ Hallucinations ____ Heart palpitations ____High blood pressure ____

Hopelessness ____ Hyperactivity ____Impulsivity ____ Irritability ____ Loneliness ____

Memory impairment ____ Mood swings ____Obsessive thoughts_____Panic attacks ____

Phobias/fears ____ Poor judgment ____ Self-esteem problems ____ Sexual difficulties ____

Sleep problems ____Social withdrawal ____ Suicidal thoughts ____ Disorganized thoughts____

Trembling____ Unresolved trauma ____ Worrying ____

Other (specify):_____

Have you ever been treated for alcohol or drug dependence/abuse? ____________________

Have you ever felt like you should cut down on alcohol or other drug use?

____

Has a friend or relative ever discussed concerns about your drug use?

____

Is there a history of problem with alcohol or drug use in your family? Please Explain:

____

Treatment for Alcohol and Substance Use

1. When?
   ____

2. Where?
   ____

Check one: Treatment was ____ helpful ___ not helpful. Please explain:

____

____

MEDICATION

Current Prescribed Medications Dose Frequency

_____________________________ ______ ___________

_____________________________ ______ ___________

_____________________________ ______ ___________

_______________________________ ______ ___________

Purpose and Side Effects

____

____

____

____