Susan Houck Strom, LMFT, ATR
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360.969.9722

CLIENT INFORMATION

NAME: ______________________________ DOB: ______________

PHONE: ______________________________

STREET ADDRESS: ______________________________

CITY/STATE/ZIP: ______________________________

e-mail: ______________________________

Emergency Contact: ______________________________
Phone: ______________________________

Who referred you to me? ______________________________

Insurance Co: ______________________________ ID# ______________

Have you had prior therapy? Where? ______________________________ Length of Time? ______________

Was it helpful? __ Yes __ No

Prior Hospitalizations Where? ______________________________ Length of Stay? ______________

Why? ______________________________

Please list any medications you are taking?
____
____
____

Are they effective?
Yes No
Yes No
Yes No

Doctor's Name: ______________________________ Phone: ______________

Why are you seeking therapy at this time?

Check any issues that apply to your reason for treatment.			
	Academic Issues		Sexual Abuse/Assault
	Relationship		Physical Abuse
	Self Esteem		Domestic Violence
	Withdrawn Behavior		Substance Use/Abuse (self)
	Sleep Problems		Substance Use/Abuse (other)
	Nightmares		Work Issues
	Eating Problems		HIV/AIDS
	Legal Difficulties		Peer/Coworker
	Sexual Problems		Children Moving Out
	Chronic Pain		Stress
	Depression, Sadness		Death or Loss
	Financial Concerns		Other Loss
	Blended Family Issues		Health Concerns
	Divorce		Age Transition Issues
	Anxiety, Panic		Suicidal Thoughts
	Anger		Self-Harming
	Add/ADHD		Recent Move
	Repetitive Thoughts		Sexual Orientation
	Other (please explain0		