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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	Withdrawn Behavior		Substance Use/Abuse (self)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		