New Client Information

Please fill out the following to the best of your ability. If you have questions about how to answer any of the following, I am glad to assist you in any way I can. We can address those questions in session.

Date:

Last Name: _____First Name: _____ M.I.: _____

Age: _____ Date of Birth: _____ Gender: _____

Street Address:

_____

City: _____ State: _____ Zip code: _____

Ok to send mail: _____ If no, please provide alternate address.

Home phone: _____ Ok to leave a message? _____
Cell phone: _____ Ok to leave a message? _____
Work phone: _____ Ok to leave a message? _____
Email address*: _____ Ok to email? _____

Employer: _____

Name of emergency contact and relationship to you: _____

Contact Information: _____

Referral Source (how you heard about counseling/therapy services):
_____

Please list any prescription and over-the-counter medications you currently take:
_____
_____
_____

Have you ever been in counseling/therapy before: _____ If yes did you find it helpful?
_____
_____
_____

Have you ever been hospitalized for mental health concerns: _____
If yes, list date(s) and length of stay:

_____
_____
_____
_____

Briefly describe why you are seeking psychotherapy and your goals in doing this work.

_____
_____
_____
_____
_____
_____

* I prefer using email to only arrange or modify appointments. If you choose to communicate information via email or text message that could identify you as a patient, please be aware you are consenting to the associated privacy risks. Email is not a secure medium, and I cannot guarantee that information transmitted will remain confidential.

This form will be retained in your medical record.