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PSYCHOTHERAPY CLIENT APPLICATION

(Please fill out completely and bring to your first psychotherapy appointment)

Name ____ Date ____________________

Address (street, city, zip)
____
____

Home Telephone ______________________ Work Telephone __________________
Occupation ____________________________ Employer _______________________
Birth Date _________________________ Referred By _________________________
Email ____

People currently living with you (name, age and relationship to you)___________
____
____

Please Check All of the Problems Below Which Apply to You:

__Career Transition
__Financial Concerns
__Life Stage Transitions
__Legal Difficulties
__Health Concerns
__Depression
__Relationship Problem
__ Anxiety
__Parent Child Conflict
__ Sleep Problems
__Blended Family Issues
__ Eating Problems
__Extended Family Issues
__ Self Esteem
__ Alcohol/Drug Problems (self)
__Alcohol Drug Problems (others)
__Suicidal thoughts

__Other Concerns

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____
____

If you have had had previous counseling, psychotherapy or hospitalizations related to mental health problems please give date(s), name of therapist and/or or hospital.

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____

Do you have any current health problems? (Include allergies)

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____

____

Please list medications you regularly take (include over the counter remedies)

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____

Have you had any significant surgery or hospitalizations? ____________________

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____

Name of Personal Physician ____

Date of Last Physical Exam ____

Is there anything not included above that you think it would be would be helpful for me to know about and you?

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Date ___________________________ Signature _______________________