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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 or Cell 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
_____ _____
_____ _____

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

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

_____

_____

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

_____

_____

Have you had any significant surgery or hospitalizations?

_____

Name of Personal Physician _____

Date of Last Physical Exam _____

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

_____

_____

_____

Date _____

Signature _____