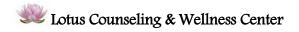


Client Information

Date:							
Name:			Social Security #				
Address:		City:		State:		Zip:	
E-mail address:		•	May we contact you by e-mail?				
Cell Phone:		Home Phone:					
Marital: M S W D DP SEP	Race:		DOB:			Age:	
Occupation:		Employer:					
Employer's Address:			Office Tel:				
Spouse:			How long together?				
Occupation:			Employer:				
If client is a minor - Parent / Guardian Information:							
Guardian Name:			DOB:		DOB:		
Guardian Address (if different from above):							
City:			State:		Zip:		
Minor's School:					Grade:		
Name of Emergency Contact:			Phone:				
Address:		City:			State:	Zip:	
Relationship to Client:			Consent/Release Form: Yes / No			: Yes / No	
Name of Primary Physician:			Phone:				
Address:		City:			State:	Zip:	
Consent/Release Form: Yes /No If no, briefly explain why:							
Name of Psychiatrist:					Phone:		
Address:		City:			State:	Zip:	
Consent/Release Form: Yes /No If no, briefly explain why:							
How were you referred to our office?							
Reason for Seeking Services:							
Purpose of this appointment:							



Yes Have you ever had the same or a similar issues/condition? No If yes, when, and describe: What total percentage of time during the day (at home and at your job) do you spend: Under normal stress load: _____% Under considerable stress: _____% Resting or relaxed: _____% *total should add up to 100% NO SYMPTOMS/STRESS EXTREME SYMPTOMS/STRESS (Please place an "X" on the line above to indicate level of problem.) What are your hobbies / what do you do for fun? What medications or drugs are you taking? (below list name / dosage / prescribing doctor): Other Family / Household Members: *Relationship to client, ie.child, sister, roommate, father, cousin etc. **attach an additional page if needed Age: Name: Willing to Participate? Relationship: Yes / No Age: Name: Relationship: Willing to Participate? Yes / No Age: Name: Relationship: Willing to Participate? Yes / No Age: Name: Willing to Participate? Relationship: Yes / No Age: Name: Willing to Participate? Yes / No Relationship: Client's Signature: _____ Date:____ Guardian's Signature Authorizing Care:______ Date:______

Therapist/Coach's Signature ______ Date:_____