Lotus Counseling & Wellness Center

Feather Sound Square
2325 Ulmerton Road, Suite 11C
Clearwater, FL 33762
Tel. 727-744-2559

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:		N/A	
Guardian Name:		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	
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:			

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Have you ever had the same or a similar issues/condition? ____ Yes ____ 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*

Name:	Age:
Relationship:	Willing to Participate? Yes / No
Name:	Age:
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Client's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

Therapist/Coach's Signature _____ Date:_____