Ariella Goodwine Fisher, M.S., LMFT
Client Information
Collaborative Divorce

Name:_____ Today's Date: _____

Date of Birth: _____ email: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: cell: _____ okay to leave a message? yes ___ no___

home: _____ okay to leave a message? yes ___ no___

work: _____ okay to leave a message? yes ___ no___

Emergency Contact #1:_____

Relationship:_____

Phone #: _____

Emergency Contact #2:_____

Relationship:_____

Phone #: _____

Employer: _____

Are you currently working with a psychotherapist? yes ___ no___

Please list the names and contact information for your Collaborative Team:

- Attorney_____
    - Phone number:_____ Email: _____
- Financial _____
    - Phone number:_____ Email: _____
- Child Specialist _____
    - Phone number:_____ Email: _____

Length of marriage: _____

Names and ages of children: _____

_____

_____

Do you have a history of substance abuse and/or dependence? If yes, please describe.

What are your goals for the collaborative process (i.e. how do you hope that collaborative will help you through the divorce process)?

In the past 3 months, have you experienced any of the following symptoms at a level that you would consider significant? Please check all that apply.

__ Aggression
__ Anger
__ Anxiety/Panic
__ Apathy
__ Avoidance
__ Compulsive Behavior
__ Crying
__ Depression
__ Difficulty Concentrating
__ Fear
__ Flashbacks
__ Guilt/self-blame
__ Harm to others/threats to others
__ Hyperactivity
__ Irritability
__ Memory problems
__ Nightmares
__ Phobias/Fears
__ Self-destructive relationships
__ Self-harm behaviors or impulses (i.e. cutting/burning)
__ Sexual acting out
__ Sexual dysfunction
__ Substance abuse
__ Physical symptoms
__ Suicidal thoughts
__ Sleep problems (sleeping too much/not enough)
__ Disordered eating symptoms
__ Other:_____

If you would like to describe any of the above symptoms further, please do so here: