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

Name:________________________________ Today's Date: ___________________________

Relationship Status: --Married --Divorced --Single --Domestic Partner

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___

Primary Medical Doctor: ____

Phone #: ____

Psychiatrist (if applicable): ____

Phone #: ____

Please list any medications, including dosage, you are currently taking:

Employer/School: ____

Emergency Contact #1:____

Relationship:_____________________________________

Phone #: ____

Emergency Contact #2:____

Relationship:_____________________________________

Phone #: ____

Referral Source: ____

Have you ever been in therapy before? If so, please describe type and length of treatment.

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

Have you ever been hospitalized for mental health reasons? If yes, please explain including dates and length of stay.

Have you ever attempted suicide? If yes, please list approximate date(s).

Please indicate your goal(s) in therapy.

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: