

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.

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

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