Client Information

Name: ________________________________ DOB:______________

Address (Street/Apt #): ____

City/State/Zip: ____

Home Phone: ____________________ Cell Phone: ____________________

Work Address (Street): ____

City/State/Zip: ____

Work Phone: ____________________

Payment Method: ____

Emergency Contact: ____________________ _____________ _____________

Name Relationship Phone

Please answer the following questions as best you can. Take some time to listen deeply and consider your response. Use the back of each page if you need more space, referring to the question number.

Call to the Work:

1. What is prompting you to schedule an appointment with me at this time?

2. What feels important for me to know about your pressing, current symptoms—including emotional states, dreams, challenges, places of feeling stuck, body symptoms, and anything else that seems important?

Your Vision for the Work:

3. Our work together may be brief or extended, depending on your needs and goals. You may feel that you know now exactly what you want from our work together, and it is also possible that our work together will help to clarify and shift these goals. Please use the space below to write briefly about what your goals, needs, and hopes are for counseling / psychotherapy at this juncture in time.

Issues affecting the Work:

4. Do you have any medical condition that I should be aware of? ________Yes _______ No
If yes, please describe in the space below:

5. Have you ever been hospitalized for mental health reasons? ________ Yes ________ No
If yes, please describe in the space below:

6. Have you had past or current thoughts or actions of harm to self or others? _______ Yes
_______ No If yes, please describe in the space below.

Lisa Fladager, MCAT, LMHC, R-DMT, CMA
PO Box 861, Langley, WA 98260
(360) 221-2677 temenos@lisafladager.com

7. Have you experienced past or current physical, sexual, emotional, or mental abuse or trauma?
____ Yes ____ No   If Yes, please describe below what you feel able to write at this time.

8. Please list all of your current Health Care Providers:

Name	Phone	Address	Type of treatment	Frequency of visits

9. Please list all your current medications or nutritional supplements (if any)

Medication or Supplement Name	Dosage and Frequency (e.g., 50 mg 2x/day)	Purpose and Side effects (if any)

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10. Please name and briefly describe the important people and relationships in your life at this time:

11. Please note below anything that seems important regarding your experience and relationship in your family of origin:

12. Have you struggled with addiction or compulsion of any kind? ______ Yes ______ No
If yes, please describe below—include whether or not you received treatment, and your current relationship to this issue:

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