Pamela J. Firle, MA, LPC, CWC

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CLIENT INFORMATION

Name: _____ Date: _____

Mailing address: _____

Phone: _____ Email: _____

Date of birth: _____ Age: _____

Name of Emergency Contact (required for Telehealth): _____

Emergency Contact phone: _____

Occupation: _____ Spouse or Partner's Name: _____

Marital Status: single__ married__ separated__ divorced__ domestic partners__ widowed__

Others living in your home: _____

How did you find my practice? _____

Presenting Problem - Please check all that apply

Alcohol	_____	Divorce	_____	Life transition	_____
Anger	_____	Drug abuse	_____	Marital issues	_____
Anxiety	_____	Eating habits	_____	Overwhelm	_____
Chronic stress	_____	Family issues	_____	Sexual abuse	_____
Crime victim	_____	Fear	_____	Sleeping habits	_____
Death/grief	_____	Guilt	_____	Suicidal	_____
Depression	_____	Legal issues	_____	Other	_____

Describe "other:" _____

_____

Describe duration of problems: _____

Past counseling experience (when, where, how long): _____

_____
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Prescription medications: _____

_____

Nutritional supplements: _____

_____

Known medical conditions: _____

Regular exercise/movement: _____

Describe your support system: _____

What is your spiritual orientation? _____

Name of Primary Care physician: _____

Psychiatric hospitalizations: _____

Family History:

Parents: Location if living _____

Date of divorce or deaths if applicable: _____

Siblings (how many, older or younger than you?): _____

_____

Current nature of family relationships: _____

_____

Other Information important to you: _____

_____

_____

_____