EVERGREEN
• THERAPY •

Date: _____

Client Information

Name(s):

Date of Birth:

Home Address:

Preferred Phone Number:

Alternative Phone Number:

Email Address:

Occupation(s):

Marital Status (please circle): Never Married Married Remarried Partnered Divorced Separated Widowed

Please list any previous medical diagnoses and current medical issues:
(If multiple family members being seen, list family member name next to diagnoses)

Please list any previous mental health/substance abuse related diagnoses:
(If multiple family members being seen, list family member name next to diagnoses)

Please list all current medications:
(If multiple family members being seen, list family member name next to diagnoses)

Name of Primary Care Physician:

When was your last visit?

Name of Psychiatrist (if applicable):

When was your last visit?

Please list any previous psychiatric hospitalizations or inpatient treatments for mental health and/or substance abuse:

Have you received psychotherapy and/or counseling in the past? If yes, what did you find most helpful? Least helpful?

Have you ever considered or attempted suicide? If yes, when?

Emergency Contact Name:

Emergency Contact Phone Number:

Emergency Contact Address:

Therapy Participants

Name	Relationship	Date of Birth	Where living?

Briefly state your reason for seeking therapy at this time:

What do you hope to accomplish in therapy?