

Integrative Therapy of Greater Washington

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Client’s Name: Today’s Date:

Street: City: State:

Zip: Home Phone: Cell Phone:

Employer: Work Phone:

Email:

\*Please indicate the best number to reach you at or best way to contact you

Can we leave a message identifying who we are? Yes No

Work Address: Occupation:

Sex: *Male Female* Ethnicity: Date of Birth: Age:

Marital status (circle all that apply): *Single Engaged Living together Married Separated Divorced Widowed*

Name of Spouse: Spouse’s Employer:

E-mail: Referred by:

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| --- | --- | --- | --- | --- | --- |
|  | Names of Children: | Age | Gender | Living w/ you? | Comments: |
|  |  |  | *M F* | *Yes No* |  |
|  |  |  | *M F* | *Yes No* |  |
|  |  |  | *M F* | *Yes No* |  |

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| Briefly state your reason for seeking counseling at this time: |

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| Have you or a family member ever been seen by a mental health professional before? *Yes No* If yes, please indicate who, when and why: |

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| Do you regularly practice relaxation techniques (e.g. meditation, yoga, Tai Chi)? *Yes No*  If yes, what and how often?  How often do you get 20 minutes or more of exercise?  Do you smoke? If so, how much each day?  How much alcohol do you usually drink?  Do you use “recreational” drugs? *Yes No* If yes, what and how often? |

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| --- | --- | --- | --- | --- | --- | --- |
| Who is your primary physician? Phone #: | | | | | | |
| Please list any troublesome or significant medical conditions you may have. | | | | | | |
|  | Please list your current medications (Prescription & Non-Prescription): | | | | | |
|  | Drug | Dose | Frequency | When Started | For what symptom(s) | Prescribing Doctor |
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Who is in your social support network?

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| Who should be notified in case of emergency?  Name: Relationship: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone: Work Phone: Cell: |