Somatic Psychotherapy

NEW CLIENT INFORMATION FORM

Name _____
LAST FIRST MIDDLE

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Telephone Home _____ Work _____ Mobile _____

Other _____ Where can I leave messages? _____

Employer / School _____ Occupation _____

Education / Training (Highest Level Attained) _____

Military Service ☐ Yes ☐ No Dates _____ Did you serve in combat? ☐ Yes ☐ No

Birth Date _____ Age _____ Childhood Nicknames _____

Sexual Orientation ☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual

Relationship Status ☐ Married ☐ Never Married ☐ Widowed ☐ Single
☐ Divorced ☐ Separated ☐ Living together as partners

If married, duration of present marriage _____ Are there children living at home? ☐ Yes ☐ No

Names and ages of children _____ Age _____ _____ Age _____

_____ Age _____ _____ Age _____

Spouse / Partner's Name _____ Age _____

Previous Marriages (Date / How ended) _____

Have you had previous therapy? ☐ Yes ☐ No Spiritual or Pastoral Counseling? ☐ Yes ☐ No

When? _____ With whom? _____

Are you presently seeing a therapist? ☐ Yes ☐ No If yes, whom? _____

How did you hear about me?

☐ Clergy Person ☐ Social Service Agency ☐ Family
☐ Friend ☐ Employer ☐ Advertisement
☐ School ☐ Former Clients ☐ Physician or Other

Please include specific name if appropriate _____

FERN SNOGREN, LCSW, MA, CHT 629 ALTAMONT ST. ASHLAND, OR 97520 541-482-3328 FAX 541-982-2265

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Your Physician's Name _____ Date of last medical exam _____

Are you currently on medication? ☐ Yes ☐ No

If so, which medication(s)? _____

Prescribed by _____ Major surgeries in the past five years? ☐ Yes ☐ No

For which condition(s)? _____

Other health-related conditions _____

What is your current physical condition? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

What is your current emotional condition? ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent

Which of the following describe or relate to the concerns that bring you here?

☐ Aging Issues
☐ Anger
☐ Anxiety
☐ Frequent Crying
☐ Eating / Food
☐ Alcohol / Drugs
☐ Loneliness
☐ Self Doubt
☐ Life Transition
☐ Guilt
☐ Sexual Concerns
☐ Fear
☐ Grief
☐ Mid-Life Issues
☐ Suicidal Feelings
☐ Religious Doubts
☐ Legal Issues
☐ Finances
☐ Vocation/Career Issues
☐ Physical Health
☐ Self-Esteem
☐ Poor Appetite
☐ Self Loathing
☐ Sleep Disturbances
☐ Hopelessness
☐ Weight Loss

Relationship with:
☐ Partner
☐ Parents
☐ Children
☐ Others

Loss of:
☐ Self-Respect
☐ Identity
☐ Faith
☐ Meaning
☐ Love

Abuse Issues
☐ Sexual
☐ Physical
☐ Emotional
☐ Verbal

State in your own words the concerns that bring you to therapy: _____

_____

_____

How will you know when your current concerns are resolved? _____

_____

_____

Emergency Contact _____ Phone _____

Relationship _____

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