LDS THERAPISTS GROUP

1904 Skypark Drive, (541) 292-9452

INITIAL CONSULTATION FORM

Name: _____

Date: _____

Address: _____

Phone:_____ Email: _____

Please check all that apply…

Marital Status: ( ) Married ( ) Single ( ) Divorced

( ) In a serious relationship ( ) Widowed ( ) Recent Breakup

Children: (Names and Ages)_____

_____

_____

List any current health problems and medications currently taking:_____

_____

Are you currently seeing another therapist? _____

Have you sought counseling in the past? _____

If so, when and why? _____

_____

What was the outcome of past therapy? Please describe what part was successful and what didn't work_____

_____

_____

_____

Please number all that apply 1-5 (1 high frequency - 5 low frequency):

( ) anxiety ( ) depression ( ) difficulty sleeping ( ) fear/worry

( ) mood swings ( ) stress ( ) unusual eating patterns

( ) headaches ( ) obsessive thoughts ( ) angry outbursts

( ) fear in social settings ( ) desire to be alone ( ) addictions

( ) feeling out of control ( ) thoughts of body image

( ) feeling isolated or alone ( ) desire to not be touched

What is the main reason you are here today?

_____

_____

_____

_____

_____

Please describe what things in your life would look like if the main problem(s) was solved:

_____
_____
_____
_____

Please list other goals that you would like to work on in therapy_____

_____
_____
_____
_____

Sign here: _____

This form is strictly CONFIDENTIAL.