

CLIENT INFORMATION SHEET

Full Name: _____

Phone: _____

Email: _____ Age: _____

Religious Preference: _____

Marital Status: _____

1st marriage: Date(s) _____ Spouse _____ Children _____

2nd marriage: Date(s) _____ Spouse _____ Children _____

Who has custody of your minor children? _____

Have you ever considered suicide? _____ Attempted? _____

Do you suffer from: Migraines _____ Epilepsy _____ Seizures _____ Vertigo _____

Circle any of the following that are currently causing you difficulty:

Addiction

Food

Panic attacks

Anger

Gender issues

Parents/In-laws

Anxiety

Grief

Phobia

Assertiveness

Hearing voices

Physical health

Career

Hopelessness

Pornography

Depression

Identity

Self harm

Divorce

Legal issues

Self-Control

Energy

Marriage

Sexuality

Fertility

Nightmares

Suicidal thoughts

Other _____

What is your birth order? (i.e. oldest, youngest, of how many, etc.)

How will you be different if this work is successful?

Statement Of Confidentiality

The Client-Practitioner relationship offers confidentiality in so far as allowed by the laws of the State of Colorado. Under certain conditions, the right to confidentiality is necessarily violated. Those conditions include the potential for suicide or homicide on the part of the client. Likewise, when there is reason to suspect that physical or sexual abuse has occurred to a child or an elderly person, the practitioner is required by law to report the situation to the Department of Human Services, division of Child Protective Services.

Thank you for completing this questionnaire.

Your Signature

Date