Maggie Weisenberger, LCSW-S, RYT
Wise Zen Therapy, PLLC
(609) 467-8746

CLIENT INFORMATION FORM

Name: _____ Birth date: _____ Age: _____

Address: _____ City, State, Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Email: _____

What is your preferred method of contact? _____

Emergency Contact Name, Relation and Number: _____

Educational Background: _____

Current Place of Employment: _____

Who referred you or how do did you find out about this service? _____

_____

Are you experiencing any of the following? (Check all that apply)

Feelings:	_____ Numbness	_____ Sadness	_____ Loneliness	_____ Anxiety
	_____ Fatigue	_____ Shock	_____ Fear	_____ Helplessness
	_____ Relief	_____ Depression	_____ Guilt	_____ Anger
	_____ Freedom			
Thoughts:	_____ Disbelief	_____ Confusion	_____ Preoccupation	
	_____ Deceased is Present	_____ Hallucinations		
	_____ Harming Myself	_____ Harming Others		
Behaviors:	_____ Sleep Problems	_____ Dreams	_____Restlessness	
	_____ Absentmindedness	_____ Change in Appetite	_____ Substance Abuse	
	_____Searching/Calling out	_____Avoiding Reminders	_____Social Withdrawal	

To whom are you currently going for emotional support? _____

_____

_____

Please list all medications you are currently taking, the reason for taking them, how long have you been taking them, and the name of the doctor that prescribed them: _____

_____

_____

Have you ever been in therapy/counseling before and for what reasons?

_____

_____

_____

_____

What is the reason for seeking out counseling? _____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

Current relationship status: _____ (Married, Single, Divorced, Widowed, Living with Someone)

Name: _____ Age: _____

Please list all members of your immediate family (Children/Step/Grand, Parents/Step/Grand, Siblings, Other Close Relations), their ages, and a brief description of your relationship with them: _____

Is there anything else you can think of that will be helpful for me to know about you? _____