Debi Circle, M.A.
Psychotherapist

Client Information Form

Client first and last name____

Client Address/City/Zip____

Client cell phone number______________________

Is it ok to text you? I cannot guarantee it to be secure. Yes______ No______

Client email address (optional) ____

Is it ok to email you? I cannot guarantee it to be secure. Yes _____No_____

Contact Person Name, Relationship and Phone Number in case of Emergency__________________________

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Reason for seeking counseling at this time____

____

How would you rate your level of concern or debilitation on a daily or weekly basis with this issue? (0 not at all--10 it has really impacted me significantly)____

How would you want areas in your life to look or feel differently as you address this issue(s) ____

____

If you have been in counseling before, what were the benefits? What were the frustrations or disappointments? ____

____

What medications or supplements are you currently using and what is it for? Does it help? _______________

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How much alcohol do you drink daily or weekly? __________________ Does this feel like a problem to you or others? Yes_______ No_______ How often do you use cannabis? __________________ Does this feel like a problem to you or others? Yes_______ No________

Thank you for taking time to fill this out. Please bring this in to our initial session. I look forward to meeting you!