



5700 23rd Drive West, Everett, WA 98203
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Confidential Initial Information Form

Date: _____

Personal

Name: _____

Address: _____ City: _____ Zip Code: _____

How long at this residence: _____ Number of persons living me: _____

Living with: _____

Home Phone: _____ Mobile: _____ Emergency: _____

Please circle which number is best to leave a message at.

Email address: _____

May I contact you by email? _____ How often do you check email? _____

Age: _____ Birthdate: _____ Birthplace: _____ Ethnicity: _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Length of present relationship: _____ Age of partner: _____

Dates of previous marriage(s) _____

How long did you know your spouse before marriage? _____

Will your partner be involved in therapy? _____

Work/Education Record

Occupation: _____

Employed By: _____

Length of employment: _____ Business Phone: _____

Unemployed since: _____ Reason: _____

Education (last year completed): _____ Highest degree earned: _____

Ever promoted _____ yes _____ no Ever held back _____ yes _____ no

Military experience: _____

Gross Household Income: _____ (mo./yr.)

Health

Significant Medical Conditions: _____

Current medications:	Reason for:	Dosage:	Frequency:	Began on:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Spiritual & Religious

Do you believe in God? (Briefly describe) _____

Sunday church attendance: _____ Never _____ Rarely _____ Occasional: _____ Regular _____

Other church involvements: _____

Church Preference? _____ Member of? _____

Family of origin's religion/practice: _____

What are your hobbies or areas of interest? _____

How would you rate the overall functioning level or quality of life right now? *Please circle one*

- 1. Unable to function in most areas
- 2. Serious difficulty functioning most days
- 3. Mild to moderate difficulty
- 4. Minimal difficulty
- 5. No difficulties, rare occurrences

What are your 3 worst fears? _____

What are 3 wishes you may have? _____

Experiences

Use a check mark to endorse which of the following are true using the following scale:

1= mild 2=moderate 3=significant 4=extreme 5= unmanageable

If the experience was in the past and not current, mark with a **P**.

Have **YOU** experienced:

Have you or a family member experienced:

YOU

YOU Family

	YOU		YOU	Family
Memory Problems		Fever		
Anxiety or panic		Breathing problems		
Depression		Night sweats		
Suicidal thoughts		Heart attack		
Bad home conditions		Stroke		
Fear		High blood pressure		
Unwanted thoughts		Diabetes		
Dizziness		Cancer		
Worrying		Epilepsy		
Stomach pains		Thyroid problems		
Changes in weight		Hypoglycemia		
Loss of appetite		Alcoholism		
Eating too much		Gambling		
Sleeping difficulties		Drug addiction		
Falling asleep		Sex/love addiction		
Staying asleep		Eating disorders		
Waking early		Suicide		
Nightmares		Obsessions		
Learning/school problems		Hospitalizations		
Racing thoughts		Mental illness		
Guilt		Mental abuse		
Sexual preoccupation		Physical abuse		
Headaches		Sexual abuse		
Financial Problems		Homosexuality		
Inferiority Feelings		Joblessness		
Shy with others		Significant death/loss		
Afraid of others		Fainting spells		
Over ambitious		Anger		
Other:		Other:		

How did you hear of my services? _____

Referred by: _____

Other comments: _____
