CLIENT INFORMATION

PLEASE PRINT

Name_____Age _____DOB _____ Date_____

Address_____
No and street City State Zip

Email address (optional)_____

Phone-Home#_____Work#_____Cell#_____

You may leave messages on: (Please circle) Home Work Cell

Emergency Contact Person_____Phone#_____

Your Occupation_____Work days/hours _____

Marital Status: :(Please circle) Married Separated Divorced Living together Single

Spouse's/Partner's Name_____

Children's names and ages _____*_____*_____*_____

Currently who is living in our home _____

Health Issues(Current)_____

Treating Physician Name and Phone #_____

Referred by_____

I understand that I am responsible for the full fee at the time of each appointment and further that I will be charged for missed appointments, unless the appointment is cancelled or rescheduled at least 24 hours in advance.

In case of Emergency call:

24 Hour Crisis Line (916) 920-2925 or 911

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Deborah Jones-Toohey ~ MA Transformative Arts
imagePathways * 461 Main Street Newcastle, Ca 95658
(916) 672-8409 * (916) 652-7709

Please list any significant medical problems.

_____

_____

Please list any hospitalizations with dates and reasons.

_____-

_____

Please list any previous psychotherapy, type of therapy, reason for seeking treatment, how long in duration, whether it was helpful.

_____

_____

_____

Please describe what you'd like to achieve from therapy now.

_____

_____

_____

How long has this issue been a problem for you?

_____

What other healing modalities have you done to try and address this issue so far?_____

_____

Please describe any additional information that you think I should be aware of (Use back if necessary)_____

_____

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