Tracie Morrison Salmon, LPC, LMFT, LCDC

INITIAL INTERVIEW FORM

CLIENT INFORMATION: **Date: _____**

Name: _____

Phone: (cell)_____DOB:_____

Email Address: _____

May I have permission to call/text/email all the above numbers: YES___ NO_____

Address: _____ City: _____
State: _____ Zip: _____
May I have permission to mail to this address? Yes_____ No_____
***Date of Birth*:_____ Sex: Male___ Female____**
Others living at home:_____

Employer:_____
Occupation:_____
How long have you worked there?_____ How long in this occupation?_____
Education:_____

Primary Physician:_____ Phone:_____
List any significant health problems:_____
_____
_____
List any medications you are taking, for what condition, and dosage/frequency, and doctor: _____
_____
Have you seen this type of therapist before? YES____ NO _____
If yes, when and with whom? _____
Give a brief description of treatment: _____
Did past therapy help? _____

How were you referred to this office? ____Insurance ___Psychology Today ___Therapy Sites _____Internet /Google search words ___Friend
Who may I thank for referring you?_____

Emergency contact: _____(cell)_____
Permission for Tracie M Salmon, LPC to talk with _____(cell)_____concerning my treatment.
Signature of patient: _____ .