

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: _____ .