Tracie Morrison Salmon, LPC, PA

INITIAL INTERVIEW FORM

CLIENT INFORMATION: **Date: _____**

Name: _____

Phone: (wk)_____ _____ (cell)_____

Email Address: _____

May I have permission to call 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: (List highest level of education attained)_____
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: _____
_____

How were you referred to this office? ____Insurance ___YP ___Internet ___Friend
Who may I thank for referring you? _____

Emergency contact: _____
Permission for therapist to talk with _____concerning my treatment. Signature of patient: _____