Sibel Golden, PhD, LMHC

Psychotherapy

Name_____ **Date**_____

Date of Birth_____/_____/_____ **Current Age** _____ **years**

Social Security # _____-_____-_____

Address _____

Primary Phone _____ **Secondary Phone**_____

Email _____

Emergency Contact Information

Name_____ **Relationship to client**_____

Phone_____

What is your reason for seeking a therapist at this time?

Have you seen a therapist or counselor in the past?
If so, when? How long? For what reason? Was it helpful? Why or Why not?

Are you in family/ couples therapy at this time?
Have you ever been a patient in a mental health, substance abuse or other treatment facility?
If so, when? In-patient or day treatment? How long? Please explain:

Do you have a history of depression? Are you feeling depressed now?

Do you have a history of anxiety? Are you feeling anxious/ having panic episodes currently?

Do you have any health problems or illnesses? If so, please explain:

Are you currently taking any medication? If so, what and how much?

Are you working with another healthcare provider at this time? Please explain:

How do you envision therapy at this time?
What are your hopes/ needs/ expectations/ concerns/ fears about being in therapy?

By signing below, you acknowledge that you have received a copy of the client disclosure form:

***Signature*_____ *Date*_____

By signing below, you acknowledge that you have received a copy of the HIPAA information regarding privacy practices:

***Signature*_____ *Date*_____