Waking Heart Therapy, LLC

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New Client Form

Please fill out this form as completely as you feel comfortable with, and bring it to your first session. The information you provide here is protected as confidential information.

DATE _____Full name: _____

Birth Date: _____ /_____ /_____ Age: _____

Current Address:_____
(Street and Number)

_____

(City) (State) (Zip)

Home Phone: (_____) _____ May I leave a message? □Yes □No

Cell/Other Phone: (_____) _____May I leave a message? □Yes □No

Work Phone: (_____) _____ May I leave a message? □Yes □No

E-mail: _____May I email you? □ Yes □ No

Referred by (or how did you hear about Waking Heart Therapy, LLC and Teri Dillion?)

_____

What prompted you to choose Waking Heart Therapy, LLC and Teri Dillion?

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ Yes, previous therapist/practitioner: _____

Please describe your history of mental health services_____

_____

Last Physical Exam (Date) ____/____/____ Name of PCP: _____

Please list any prescription medication and dosage you are currently taking?

_____

Have you ever been prescribed psychiatric medications □ Yes □ No

Please list and provide dates:

_____

Please check which issues below you are experiencing:

Physical Illness/Lack of health	Anxiety	Depression
Grief/Loss	Delusions/Paranoia	Panic
Phobias	Compulsive internet use	Compulsive sex/porn use
Compulsive Eating/disorder	Drugs:	Alcohol
Worry	Confusion, memory problems	Unstable moods
Isolation/Loneliness	Lack of interest in life	Work stress
Relationship issues/conflict	Codependence	Impulsive illegal behaviors
Anger issues	Fear	Difficulty expressing emotions
Transition stresses	Lack of goals/direction	Uncontrollable behaviors
Lack of life satisfaction	Suicidal feelings/behavior	Self-harming behaviors
Past trauma	Past abuse	Past neglect
Significant Injury	Sleep problems	Other:

Please add notes regarding the issues checked above:

_____
_____
_____
_____
_____
_____
_____

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____ How satisfied are you with your relationship? _____

What significant life changes or stressful events have you experienced recently:

_____

_____

ADDITIONAL INFORMATION

Are you currently employed? □ No □ Yes If yes, where are you employed: _____

If yes, what is your current employment situation: □ Full Time □ Part Time □ Laid Off

□ Medical Leave (Stress or Injured) □ Other (explain): _____

Do you consider yourself to be spiritual or religious? _____

What do you consider to be some of your strengths?

_____

What do you consider to be some of your weaknesses?

_____

What would you like to accomplish out of your time in therapy? My Goals are:

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

Please rate your expectations for therapy:

	Not important	Of Minor Importance	Of Major Importance
Nonjudgmental listening and understanding			
Help focusing on goals to resolve challenges			
Active guidance and suggestions for steps to take			
Reminders of past successes and strengths			
Resources (books, groups, etc) that may be helpful			

Validation of my feelings and a sense of caring			
Homework assignments to practice between sessions			
A different way of seeing myself and my situation			
Referral to a psychiatrist for medication			
Other:			

How long do you see yourself being in therapy? _____

Is there anything else you feel might be important for me to know about you?

_____

_____

_____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

CANCELLATION POLICY

If you fail to cancel a scheduled appointment a full 48 hours in advance you will be billed for the entire cost of your missed appointment. I make exceptions for county snow days and medical emergencies.

_____ _____

Client Signature (Parent/Guardian/Legal Representative, if under 18) Date