Sonya Brewer, MA

Licensed Marriage and Family Therapist #89901

Somatic Psychotherapy for Body, Mind, Heart & Spirit

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CLIENT INFORMATION FORM

Please provide the following information for my records. If some of this information feels too personal to share, you can leave those questions blank. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself fifteen minutes prior to your appointment to complete the form in the office.

Date of Initial Appointment: _____ /______ /_____

Legal Name______________________________________ Preferred Name________________________________

Address ____

City, State, Zip ____

Birth date _______ /_______ /______ Age: ___________________

Current Work / School: _____________________________________

Home Phone _____________________________ May I leave a message? ❒ No ❒ Yes

Cell Phone _____________________________ May I leave a message? ❒ No ❒ Yes

Other Phone _____________________________ May I leave a message? ❒ No ❒ Yes

E-mail* ____ May I email you? ❒ No ❒ Yes

(*Please be aware that e-mail may not be confidential.)

Gender: ❒ Female ❒ Male ❒ Transgender ❒ Declined to state ❒ Other: ________________________

Preferred Gender Pronoun(s): ____

Disability:❒ Yes ❒ No If yes, please describe: ____

Ethnicity(ies): ____ ❑ Declined to state

Sexual Orientation: ❒ Heterosexual ❒ Lesbian/Gay ❒ Queer ❒ Bisexual ❒ Asexual ❒ Undecided ❒ Declined to state ❑ Other: ___________________________

Relationship Status: ❒ Single ❒ Partnered ❒ Married ❒ Polyamorous ❒ Divorced ❒ Widowed ❒ Separated ❑ Other: ____________________

Referred by: ____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?
❒ No ❒ Yes

Current service providers' names: ____

Have you had previous psychotherapy? ❒ No ❒ Yes

Previous psychotherapist's name: ____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ❒ No ❒ Yes

If yes, please list: ____

If No, have you *previously* taken prescribed psychiatric medication? ❒ No ❒ Yes

If yes, please list: ____

HEALTH INFORMATION

1. How is your physical health at present?

   ❒ Poor ❒ Unsatisfactory ❒ Satisfactory ❒ Good ❒ Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

   ____

   ____

3. When did you last consult with your primary care physician? ______________________________

4. Are you having any problems with your sleep habits? ❒ No ❒ Yes

   If yes, check where appropriate: ❒ Sleeping too little ❒ Sleeping too much
   ❒ Poor sleep quality ❒ Disturbing dreams ❒ Other

5. Are you having difficulty with appetite or eating habits? ❒ No ❒ Yes

   If yes, check where appropriate: ❒ Eating less ❒ Eating more ❒ Binging
   ❒ Restricting ❒ Other

6. Do you regularly use alcohol? ❒ No ❒ Yes

   How often?

   ❒ Daily (how many drinks per day? ______) ❒ Weekly (how many nights per week? _______)
   ❒ Monthly ❒ Rarely ❒ Never

7. Do you engage in recreational drug use? ❒ No ❒ Yes

   How often?

   ❒ Daily (How often per day? _______) ❒ Weekly (How many nights per week? ________)
   ❒ Monthly ❒ Rarely ❒ Never

8. Have you had suicidal thoughts recently? ❒ Frequently ❒ Sometimes ❒ Rarely ❒ Never

9. Have you had suicidal thoughts in the past? ❒ Frequently ❒ Sometimes ❒ Rarely ❒ Never

10. Issues of Concern (circle any of the following you are struggling with):

-depression -wild mood swings -childhood trauma -aging - anxiety

-communication problems -violence in relationship(s) -parenting stress -sexual issues

-panic attacks -phobias -sleep disturbances -relationship issues

-sexual assault -job stress -hallucinations -unexplained losses of time

-unexplained memory lapses -separation or divorce -alcohol use

-drug use -gender issues -transphobia -sexism -suicidal thoughts

-self-destructive behaviors -job stress -sexual orientation -homophobia

-frequent body complaints -eating disorder -body image problems

-self-esteem issues -infidelity -repetitive thoughts (e.g. obsessions) -chronic illness

-disability discrimination -racial identity -racism -classism

-repetitive behaviors (e.g. frequent checking, hand washing, etc.) -homicidal thoughts

11. Is there anything more you would like me to know about your concerns?

____

____

____

____

____

____

____

OTHER INFORMATION

1. In the last year, have you experienced any significant life changes or stressors?

____

____

2. Are you currently in intimate relationship(s)? ❒ No ❒ Yes

   Partner/Spouse/Chosen Family Name(s): ____________________________________

   ____

   If yes, how long have you been in this (or these) relationship(s)? ____________________

   On a scale of 1-10, how would you rate the quality of your current relationship(s)? ______________

3. # of Children ____________ Names/Ages:______________________________

   On a scale of 1-10, how would you rate your experience as a parent? ______________

   Please list any parenting stressors or challenges that feel important to share:

   ____

4. Are you currently employed? ❒ No ❒ Yes

   On a scale of 1-10, how would you rate the quality of your current work experience? ____________

   Please list any work-related stressors that feel important to share:

   ____

5. What are your goals for therapy?

   ____

   ____

6. Emergency Contact (Name/Phone Number):______________________________

Please sign here to give your consent for me to contact your emergency contact in the event of an emergency:

____