Initial Contact

Janna Flower, MA LPC

Name DOB

Address City ST Zip

Phone Email

Preferred contact method: ▫ Okay to contact by email regarding scheduling
▫ Okay to leave message on voice mail

EMERGENCY CONTACT

Name	Relationship to you
Phone	Email

DEMOGRAPHIC INFORMATION

Age	Gender	Place of Birth
Ethnicity/Race		Cultural Identification
Relationship Status		Name of Partner
Religious Affiliation		Importance to you? ▫Very ▫Somewhat ▫Not at all ▫Neutral
Occupation		Education Level

MEDICAL INFORMATION

Please list any medical conditions/diagnoses you have and current medications:

WHO REFERRED YOU?

Internet: ▫Website ▫Online directory ▫Google Please Specify search terms or directory used:
Personal referral from:
Other:

PRESENTING PROBLEM

Briefly state why you are coming to therapy and how you hope to be helped:

OFFICE USE ONLY:

▫Information for Clients ▫ Informed Consent ▫ Notice of Privacy Practices ▫ Release of Information