# PATRICIA TURNER COUNSELLING AND CONSULTATION INC.

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## New Client Information

Name: _____ Date of birth: _____

Marital status: _____ Occupation: _____

Address: _____

Postal code: _____

E-mail: _____

Phone no.: Home: _____

Business: _____

Cell: _____

Please indicate whether a telephone message can be left at any of these numbers:

( ) Home ( ) Business ( ) Cell

Referral source: Physician: _____ Internet: _____

Friend: _____ Other: _____

Emergency contact: Name: _____ Relationship: _____

Address: _____ Phone: _____

Physician: Name: _____ Phone: _____

Many physicians prefer to be informed about their patient's involvement and progress in therapy. Would you like me to discuss your participation in therapy with your physician?

( ) Yes ( ) No

Please list any medications you are taking.

_____

_____

_____

**Please be as specific as you can as you answer the following questions.**

1. What are your main concerns?

_____

_____

2. What do I need to know about you to better understand your situation?

_____

_____

3. What are your expectations for therapy? What are your goals?

_____

_____

4. Approximately how many sessions do you expect this to take?

_____

_____

5. Do you have any questions or concerns about therapy?

_____

_____

6. How will you know you have successfully finished therapy?

_____

_____