2526 Saint Paul Street, LL Baltimore, MD 21218 • 443-292-6722 • www.ShawnaMurrayBrowne.com

CLIENT INFORMATION FORM

DATE COMPLETED: ____________________

The information requested is to help me get to know you to serve you best. Please fill out this form as completely as you can. All information will be held in strict professional confidence unless otherwise directed by law.

Basic Information:

FULL NAME: ____

DATE OF BIRTH: _______________________

ADDRESS: ____

CITY: ________________________________ STATE: __________________ ZIP: ____________________

EMAIL ADDRESS: ____

HOME PHONE: ____________________________________ CELL PHONE: _________________________

______

BY WHICH NUMBER IS THE BEST TO REACH YOU? ▫ HOME ▫ CELL

Can I send you a TEXT message for scheduling purposes only? ▫ YES ▫ NO

I cannot guarantee confidentiality when you and I communicate via telephone, fax, or email. These devices could compromise confidentiality. By understanding the inherent risks of the aforementioned devices, you can make an informed choice about when / where / how to use those tools.

In case of an emergency, who would you like me to contact? ____

Phone Number:____

Relationship to you: ____

OCCUPATION: ____

LEVEL OF EDUCATION: ▫ HS Diploma/GED ▫ 2-year college ▫ Bachelor's Degree ▫ Master's ▫ PhD

EMPLOYER: ____

Referral Information

How did you learn about Kindred Wellness? ____

Health Information

Serious illnesses, injuries, or surgeries: ____

____

____

Do you have any conditions or different abilities that I need to be aware of? ____________________

____

____

Current health challenges *(if any)*: ____

____

____

Please list all medications/prescriptions that you are currently taking and why: ________________

____

Please list any other substances you consume: ____

____

How much do you exercise? What is your regular diet? _______________________________________

____

____

Tell me about your sleep:____

____

Are you feeling any physical pain in your body? Where?_____________________________________

____

Have you ever worked with a Mental Health Professional? ☐ **YES** ☐ **NO**

If so, who? ____

Why? ____

Have you ever worked with a Psychiatrist? ☐ **YES** ☐ **NO**

If so, who? ____

Last seen? _________________________ Why? ____

Have you ever tried to harm yourself or anyone else? ☐ **YES** ☐ **NO**

If so, when and how many times?____

____

Have you ever been the victim of physical (domestic violence), mental, sexual abuse? ☐ YES ☐ NO

If so, when?________________________________ Where? By whom?

____Was this investigated? ☐ YES ☐ NO

Have your ever been hospitalized for mental, chemical, or emotional concerns? ☐ **YES** ☐ **NO**

If so, when?_____________________________ Where? ____

Why? ____

Have you ever worked with a life coach or mentor? ☐ **YES** ☐ **NO**

If so, who? ____

Address & Phone Number: ____

Last seen: _______________________Why? ____

Other relevant information: ____

____

____

Goals of Integrative Therapy

What would you like to change about your behaviors/development? _____________________________

____

____

How has this been a problem? ____

____

____

When did this problem first appear? ____

____

What changes have you noticed recently? ____

____

____

How have you tried to solve this problem? ____

____

____

Why are you seeking help right NOW? ____

____

____

How will you know when the problem is solved? ____

____

Who will benefit most from solving this problem? ____

____

____

Who might be the first to notice improvement? ______________________________

____

____

Tell me about your spiritual / religious beliefs. ______________________________

____

____

____

Tell me the concerns/fears you have. ______________________________

____

____

____

Hobbies / interests: ______________________________

____

____

Change is usually difficult. In the past, what **strengths and skills** would you say you have? ***They will be helpful in solving this problem***. ______________________________

____

____

____

____

My signature below signifies that the abovementioned information is true and accurate to the best of my ability and knowledge.

______________________________ ______________________________

Client Signature Date

FOR OFFICE USE ONLY:

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