breathtaking
Holistic Counseling Services

CLIENT INFORMATION

Please fill out the following information as completely as possible: Today's Date:_____

CLIENT'S NAME:_____ _____
(First, Middle Initial, Last) (Date of Birth)

ADDRESS:_____ _____
(Number, Street) (Age)

_____
(City, State, Zip Code)

CONTACT INFORMATION:

Home Phone:_____ How would you prefer that I contact you?

Cell Phone: _____ _____

Work Phone:_____

Email: _____

Emergency Contact Person_____ Phone Number_____

PHYSICIAN:

_____ _____
(Name) (Practice Name)

_____ _____
(Address) (Phone Number)

MEDICATIONS: Include all prescription and/or over the counter medications you take regularly

Name	Condition	Dosage	Frequency	Prescribing Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Cheryl A. Rowland, LLC LPC, RYT
2021 East Market Street ~ York, PA 17402
717.843.0444
www.breathtakingyork.com
cheryl@breathtakingyork.com

INSTRUCTIONS: To assist me in helping you, please fill out this form as fully and openly as possible. If certain questions do not apply to you, are too difficult to answer, or seem objectionable, leave them blank. I will assist you in answering any questions during our first meeting as we discuss this form.

CONCERNS/PROBLEMS IDENTIFIED (Check all that apply):

___Anger Management
___Antisocial/Aggressive Behavior
___Anxiety
___Adult ADHD
___Suspected ___Diagnosed
___Chemical/Substance Dependence
___Current ___Past ___Relapse
___Childhood Traumas
___Chronic Pain
___Dependency
___Depression
___Domestic Violence
___Eating Disorder
___Educational Deficits
___Family Conflicts
___Family History of Mental Illness
___Financial Problems
___Gender Issues
___Unresolved Grief
___Legal Conflicts
___Low Self-Esteem
___Medical Issues
___Obsessive –Compulsive Behaviors
___Panic Attacks
___Parenting Problems
___Phobia
___Racial/Cultural Problems
___Inappropriate Sexual Behavior
___Sexual Abuse Perpetrator
___Sexual Dysfunction ___Male ___Female
___Sleep Disturbance
___Social Discomfort/Shyness
___Spiritual Confusion
___Thoughts/Attempts of Suicide
___Victim of Abuse ___Past ___Current
___Emotional
___Physical
___Sexual

PLEASE MAKE NOTE OF ANY OTHER COMMENTS THAT YOU FEEL ARE IMPORTANT TO THIS COUNSELING PROCESS:

_____

_____

_____

_____

_____

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