Patti Okun Body-Mind Psychotherapy: Integrating Body, Mind and Energy
602-703-6586 www.pattiokun.com

Client Information

Please complete this questionnaire to help me plan services for you. Please answer each item.

Name_____Date_____

Date of Birth_____Age____ Social Security No._____

Address_____

City_____State_____Zip Code_____

Home Phone_____ Work Phone_____

Cell_____ Email_____

May I contact you at home? Yes___ No____ Work? Yes__ No____ Cell? Yes__ No___

Email? Yes____ No____ May I add you to my email newsletter list? Yes____ No____

Highest Grade/Degree_____ Type of Degree_____

Marital/Union Status_____

Spouse/Partner Name_____Date of Birth_____

Marriage/Union Date_____Names of children & ages_____

_____

Past Marriages/Significant Relationships: (length, how did it end, children?) _____

_____

_____

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Employer_____

Occupation (former if retired)_____Does this work satisfy

you?_____ If not, please explain_____

Primary Care Physician_____Phone No._____
Any health problems?_____

Medications presently taking (be specific, including supplements, alternative medicines, treatments or herbal remedies). Note dosages, and the condition they are treating.

_____

_____

Exercise: how much? How often? Type of exercise? _____

_____

Sleep? Note any problems and how long have you had the problem? _____

_____

Do you smoke? How much? How long? Have you tried to quit? If you've smoked in the past how long has it been since you've smoked? _____

_____

Any current or past problems with alcohol or drugs? Other addictions? Have you ever received treatment for any kind of addiction/compulsion? Please specify. _____

_____

Have you ever been hospitalized for alcohol, drugs, psychological issues or eating disorders? If so, please describe. Was it helpful? _____

_____

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How much and how often do you currently drink? (Use last 6 months as a guideline) _____

_____

Has anyone in your family (parents, grandparents, siblings, spouse, children, close relatives) had a history of alcohol or drug abuse problems, significant mental health problems or other related problems? Please indicate the person and the problem. _____

_____

Have you received counseling services in the past?_____

When?_____ With whom?_____

Why?_____

Was it helpful? _____ How (be specific) _____

_____

Religion/Spirituality: How were you raised? What do you currently practice if anything? How important is religion/spirituality to you now? _____

_____

Please describe your reason for seeking counseling at this time. Please be as specific as possible- when did it start? How does it affect you? Please estimate the severity of the problem (Mild, Moderate, Severe, Very Severe) _____

_____

_____

How will you know if you are meeting your goals? What would you see yourself doing differently? _____

_____

_____

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Is there anything else you want me to know about you or your special sensitivities that would help our work go more smoothly? _____

_____

_____

Notify in case of emergency_____Relationship_____

Phone number(s)_____

Who may I thank for referring you? (optional)_____

Your Signature_____ Date_____