

Silverstream UNLIMITED, PLLC
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253-853-7049 or 206-660-9840 (cell)

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Licensed Mental Health Counselor, State of Washington #LH60133260

Welcome. Please fill out this form so I can better assist you.

Today's Date _____ Would you like an invoice for insurance reimbursement? _____
May invoices be emailed to you? _____
May invoices be handed to you in-person? _____

Name: _____ Male/Female

I prefer to be called _____

Birth date: ____/____/____ Age: _____

Home Address: _____

_____ Email _____

Phone: Home _____ Work/Cell _____

Occupation: _____ How long? _____

() Single () Partnered () Married () Separated () Divorced () Widowed

How long?: _____

Previous Marriages/Partners: _____

Spouse/Partner:

Name: _____ Phone #'s: _____

Address _____

Birth date: _____ Age: _____

Children:

Name _____ Birth date: _____ Age: _____ M/F

Name _____ Birth date: _____ Age: _____ M/F

Name _____ Birth date: _____ Age: _____ M/F

Name _____ Birth date: _____ Age: _____ M/F

Continued

Do you smoke? _____

Drink alcohol? _____ What kind/ How much/ How often? _____

Use drugs? _____ What kind/ How much/ How often? _____

Describe your caffeine intake (sources, when, how much) _____

Are you taking any medication or supplements? _____ Describe: _____

Do you have trouble sleeping? _____ Describe: _____

Have you recently gained () or lost () weight? How much/over how long? _____

Are you currently being treated for any physical or psychological condition? _____ Describe: _____

Do you have chronic pain? If yes: Where? How long? _____

Please describe any health problems/concerns: _____

Please describe any prior counseling/coaching you have received including approximate dates, name of provider, and nature of the work you did together: _____

What brought you here today? _____

What do you hope to accomplish through our work together? _____

Signature

Date
