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

Ann Silvers, M.A., LMHC
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