TheraChi Healing

Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner Status: Single/Married/Living w Partner/ Separated/Divorced

Children: How Many? \_\_\_\_\_\_ Ages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presenting Concerns (Why you are seeking service):

Emotional Symptoms (Eg: Anxiety, Sadness, Fear, Irritability):

Physical Symptoms (Eg: Pain, Illness, Discomfort, Weight Loss/Gain)

Behavioral Symptoms (Eg: Insomnia, Lashing Out, Addictive or Compulsive Behaviors):

Hobbies/Stress Relieving Activities (Eg: Exercise, Yoga, Meditation, Art, Music):

Supports In Your Life (Ex: Family Members, Friends, Clergy, Teachers, Mentors):

Are you currently or have you ever been in therapy? Yes/No

What are you hoping to get out of this experience?

Additional information that may be helpful for me to know:

