Eastside Mental Wellness

Gale Dhaliwal, PhD
13303 NE 175th Street Suite A
Woodinville, WA 98072

CLIENT INFORMATION FORM

Please complete this form and bring it to our first appointment. This form provides me with important details and contact information, while preserving our first session to discuss your needs. Please share only what you are comfortable with, and feel free to leave sections blank if you so desire**.** You may use the back of the form or attach extra pages if needed.

CONTACT INFORMATION

Full Name:

Street Address:

City:

State:

Zip code:

May I send mail to this address?
☐ Yes ☐ No

Date of birth:

Place of birth:

Age:

	OK to call?	OK to leave message?
Home Phone:	☐ Yes ☐ No	☐ Yes ☐ No
Cell Phone:	☐ Yes ☐ No	☐ Yes ☐ No
Work Phone:	☐ Yes ☐ No	☐ Yes ☐ No

	OK to email?
Email Address:	☐ Yes ☐ No

How do you prefer to be contacted?

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In case of emergency, who would you like me to contact?

Name: Phone: Relationship to you:

DEMOGRAPHIC INFORMATION

Gender:

Ethnicity:

Partner(s)/Relationship Status:

Current Living Arrangement (do you live with others?):

Occupation/Employer:

Years of Education Completed:

REFERRAL INFORMATION

How did you hear about my practice?

Current reason(s) for seeking therapy: What is bothering you most RIGHT NOW?

Estimate the severity of the issue for which you are seeking care: □ Mild □ Moderate □ Severe

Have you previously been in psychotherapy?

If yes, when and for what issues?

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Was it helpful? Why or why not?

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors?
(Indicate age, circumstances, and whether it led to hospitalization or legal problems).

Are you interested in (or currently using) any additional resources to supplement therapy?
(Check all that apply, or feel free to note details here.)

- ☐ Books (self-help, information)
- ☐ Articles or blog posts
- ☐ Podcasts
- ☐ Online videos
- ☐ Support groups
- ☐ Workshops
- ☐ Weekly homework
- ☐ Workbooks/worksheets
- ☐ Referrals to specialty providers (psychiatrist, couples therapist, etc.)

DRUG AND ALCOHOL INFORMATION

Please list any *past* drug and alcohol use. What have you used and how much?

What are you *currently* using and how much?

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Has it ever affected your work or your relationships?

HEALTH INFORMATION

Contact information for primary care physician:

Do you have any health concerns, conditions, or disabilities that I need to be aware of?

Please list all medications (both prescription and over-the-counter) you are currently taking, along with dosages, reason, and prescribing doctor.

PAYMENT INFORMATION

Would you like to receive a monthly invoice that you may be able to submit to insurance for out-of-network reimbursement?
□ Yes □ No

Would you prefer paper invoices or emailed to you?
□ Paper □ Email

THANK YOU FOR PROVIDING ME WITH THIS VALUABLE INFORMATION.