Healing Day Counseling&Psychotherapy

797 Washington Street Suite 4 Newtonville, MA 02460 phone: 617-820 8895

Personal Information

First Name: _____

Last Name:

DOB (MM/DD/YYYY):_____

Gender: _____

Name of parent/guardian (if under 18 years): _____

Marital Status:

▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated ▫ Divorced ▫ Widowed
Please list any children/age: _____

Address: _____ (Street and Number)

_____ (City) (State)

Home Phone: _____

Cell/Other Phone: _____

May we leave a message? ▫ Yes ▫ No

E-mail: _____

May we email you? ▫ Yes ▫ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Do you have a health insurance? ▫ Yes ▫ No

If yes, Insurance Name: _____

Insurance #: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
▫ No
▫ Yes

Previous therapist/practitioner: _____

Are you currently taking any prescription medication?

▫ Yes
▫ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

▫ Yes
▫ No

Please list and provide dates: _____
_____

Are you currently employed?
If yes, what is your current employment situation:
_____

▫ No

▫ Yes

Do you enjoy your work? Is there anything stressful about your current work?
_____

Do you consider yourself to be spiritual or religious? ▫ No ▫ Yes
If yes, describe your faith or belief:

_____

What do you consider to be some of your strengths?

_____
_____
_____
_____

What do you consider to be some of your weakness?

_____
_____
_____
_____

What would you like to accomplish out of your time in therapy?

_____
_____
_____