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PSYCHOTHERAPY CLIENT APPLICATION

(Please fill out completely and bring to your first psychotherapy appointment)

Name _____ Date _____

Address (street, city, zip)

Home Telephone _____ Work Telephone _____

Occupation _____ Employer _____

Birth Date _____ Referred By _____

People currently living with you (name, age and relationship to you) _____

Please Check All of the Issues Below Which Apply to You:

- | | |
|---|---|
| <input type="checkbox"/> Career Transition | <input type="checkbox"/> Financial Concerns |
| <input type="checkbox"/> Life Stage Transitions | <input type="checkbox"/> Legal Difficulties |
| <input type="checkbox"/> Health Concerns | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Relationship Problem | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Parent Child Conflict | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Blended Family Issues | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Extended Family Issues | <input type="checkbox"/> Self Esteem |
| <input type="checkbox"/> Alcohol/Drug Problems (self) | <input type="checkbox"/> Alcohol Drug Problems (others) |
| <input type="checkbox"/> Suicidal thoughts | |
| <input type="checkbox"/> Other Concerns _____ | |

If you have had had previous counseling, psychotherapy or hospitalizations related to mental health problems please give date(s), name of therapist and/or or hospital

Do you have any current health problems? (Include allergies) _____

Please list medications you regularly take (include over the counter remedies)

Have you had any significant surgery or hospitalizations? _____

Name of Personal Physician _____

Date of Last Physical Exam _____

Is there anything not included above that you think it would be helpful for me to know about and you?
