Jennifer Fairchild LCSW
THERAPY AND COACHING

# INITIAL CONSULTATION FORM

Date: _____

Name of person seeking therapy: _____DOB + age: _____

Parents name(s) or legal guardian (if under 18): _____

Street Address: _____Town: _____Zip: _____

Best # to reach you: _____Emergency contact name and #: _____

Email: _____Want to get periodic emails re: community/group happenings? Yes ☐ No ☐

What are the reasons you are seeking therapy? _____

_____

_____

What would you like to get out of coming to therapy? _____

_____

_____

What is stressing you out right now? _____

Medical – physical problems or concerns: _____

Current Medications: _____

Do you currently have thoughts of harming yourself or someone else? No ☐ Yes ☐

Were you ever hospitalized for mental health? No ☐ Yes ☐ where and when: _____

Have you been to therapy before? No ☐ Yes ☐ where and when: _____

Do you have problems with sleeping? No ☐ Yes ☐ please explain: _____

Do you have any life-threatening allergies? No ☐ Yes ☐ what kind: _____

Who may I thank for referring you? _____

Any other information you would like me to know: _____

_____

Thank you and I look forward to working with you!