

Pam McDonald, LCSW-C
At The Healing Circles Wellness Center
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Client Information

Name: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Email address: _____

Would you like to be added to my e-mail list? (You will receive occasional emails about special workshops and the Healing Matters E-Newsletter) __Yes __No

Date of birth: _____

Marital status: _____

Occupation/Employer: _____

Education: () high school () college () other _____

Children?: (names, ages) _____

Siblings?: (names, ages) _____

How did you learn about my services? _____
Do I have your permission to thank the referral source? __Yes __No

Reason for referral (presenting problem): _____

Have you had the presenting problem before in your life? If so, briefly explain and note how you handled it in the past. _____

Other current or past mental health counseling? ____ yes ____ no
If "yes", with whom and when did you receive treatment?

Have you had or currently have any chronic or serious health problems? ____yes ____ no

If yes, please use the table below and fill in the applicable information.

Condition	Age	Treated by whom?	Outcome

Current doctor: _____

Practice location: _____

Phone number: _____

Current medications, including supplements:

Are you currently under the care of a psychiatrist? ____ yes ____ no

If so, please list name: _____

Practice location: _____

Phone number: _____

Please list current psychiatric medication(s) with dosage: _____

Have you ever been hospitalized for psychiatric concerns? ____ yes ____ no

If yes, when and what for: _____

Lifestyle and Wellness:

How would you describe your diet and eating habits? _____

Do you exercise? If so, how often and what do you like to do? _____

On average, how many hours do you sleep at night? _____

Do you follow a regular sleep/wake pattern? __Yes __No

Do you smoke? __Yes __No If yes, how many cigarettes per day? _____

Do you drink alcoholic beverages? __Yes __No If yes, how many drinks do you have on average per week? _____

Emergency Contact Information:

Name of primary contact: _____

Relationship: _____ Phone: _____ E-mail: _____