Sabine Boots, M.S., LMFT
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Client Information

Name: _____ Date of birth: _____ Pers. Pronouns ___/___

Profession: _____ Marital Status: _____

Spouse/Partner (if applicable): _____ DOB: _____ Pers. Pronouns ___/___

Profession: _____

Children's names (if applicable): _____ DOB: _____School Grade: _____

_____ DOB: _____School Grade: _____

_____ DOB:_____ School Grade: _____

Mailing address: _____

E-mail address: _____

Is it OK to contact you via e-mail? Please initial: Yes _____, No _____

(due to the nature of the Internet safeguarding of information cannot be guaranteed by the therapist)

Phone number(s) I can best reach you at: _____

Referring physician/or other source: _____

If you are referred by an other health care professional, do you allow me to acknowledge receiving the referral? Please initial: Yes _____, No: _____

Previous experience with therapy? _____

Are you currently taking any medications? _____

Is there a history of depression and or suicide in your family? If yes, please explain

_____

_____

Please, answer following questions using the numbers 1-5:
1=never, 2=rarely, 3=sometimes, 4=frequently, 5=almost always (feel free to leave empty if doesn't apply)

1. I am stressed at work/school. _____
2. I blame myself for things. _____
3. I feel unhappy in my marriage/significant relationship. _____
4. I'm unhappy about my sex life _____
5. I am worried about my family. _____
6. I feel lonely. _____
7. I experience a lack of concentration. _____
8. I feel hopeless about the future. _____
9. I cannot get rid of disturbing thoughts in my mind. _____
10. I experience sleep problems. _____
11. I have headaches or stomach aches. _____
12. I have problems with my eating behaviors. _____
13. I am worried about my consumption of alcohol/or other substances. _____
14. I experience anxiety. _____
15. I feel the need for better anger management skills. _____