Mrs. Erin Vandermore, M.A. , LPC

70 Woodfin Pl, Suite WW2 Asheville, North Carolina 28801, United States

erinvandermore@medofficemail.com; www.erinvandermore.org ph: 773-351-4520

Client Information

Name: _____ Date of birth: _____

Profession: _____ Marital Status: _____

Spouse/Partner (if applicable): _____ DOB: _____

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

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