Crystal Glenn, MA, LPCC

1710 S. Amphlett Blvd, Suite 210-C, San Mateo, CA 94402 • (650) 999-0232 • crystal@talk.yoga

Client Information (Confidential)

Client Name _____ Date _____/_____/_____

Birthdate ___/____/___ Age _____ Referred by _____Is it okay to thank? Yes / No

Street Address _____

City, State, Zip Code _____, ____, _____ Is it okay to send correspondence via mail? Yes/ No

Phone _____-_____-_____ Is it okay to leave message at this number? Yes / No

Email Address _____ Is it okay to send correspondence via email? Yes / No

Emergency Contact

Please provide contact information for a person to contact in case of emergency. This contact will only be used if you or someone else is in immediate danger or if you become ill and unable to depart therapy without assistance.

Emergency Contact Name _____
Relationship _____
Phone Number ____-_____-_____

_____ (Please Initial) I agree Crystal Glenn may contact the above named person under the above listed conditions.

Personal/ Social

Occupation _____ How long? _____

Employer _____Education _____

Do you enjoy your work? Is there anything stressful about your work? _____

_____

Marital Status _____ Name of Partner _____Length of Relationship _____

Are you happy with your relationship status? Why or why not? _____

_____

Do you have children? Yes / No If yes, please list name(s) and age(s): _____

Religious affiliation/background: _____

Hobbies/Interests: _____

Use of Alcohol: _____

Use of Recreational Drugs: _____

Use of Tobacco: _____

Physical Health

Medical Condition/Diagnosis _____

Past/Current Medications _____

Past Hospitalizations/Medical Procedures/Surgeries _____

How much exercise are you getting? _____

How are you sleeping these days? _____

Are you happy with your diet? _____

Family History

(Check all that apply)

Diagnosis	Self	Family Member	Diagnosis	Self	Family Member
High Blood Pressure			Suicide		
Arthritis			Domestic Violence		
Asthma or COPD			Childhood Abuse		
Seizures			Eating Disorders		
Diabetes			Obsessive Compulsive Disorder		
Alcohol/ Substance Abuse			Schizophrenia		
Anxiety			PTSD		
Depression			Other		

Reason(s) for seeking counseling

_____

_____

_____

Mental Health History

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

What is going well in your life?

_____

_____

_____

What is not going well in your life?

_____

_____

_____

Previous counseling experiences

When	Reason	Outcome

_____

_____

_____

Hospitalizations for psychiatric and/or chemical dependency concerns

When	Where	Reason

_____

_____

_____

Consent for Therapy

By signing below, you are indicating that you have read and understand the Client Agreement/ Privacy Practices and Social Media Policy. Any questions you have about these documents and/or the therapy process have been answered to your satisfaction. You are hereby agreeing to enter into a professional therapeutic relationship with Crystal Glenn, MA, LPCC.

_____ _____

Client Signature Date