BETTE GALEN, MSW, LCSW_____
975 Arthur Godfrey Road, #305 Miami Beach, Fl 33140

NAME_____DOB_____AGE_____
Address_____
Phone #_____email address_____
Emergency Contact Name & Phone #_____
How did find
me?_____
__

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can

Have you seen a counselor previously? If yes, for what? And was it helpful?

Who is your primary care physician? Please include type of MD, name and phone number.

If you are in a relationship, please describe the nature of the relationship and months or years together.

What is your current occupation? How long have you been doing this occupation?

Please check any of the following you have experienced in the past six months:

change in appetite___trouble concentrating___difficulty Sleeping___low motivation__

isolation___fatigue/low energy___low self esteem___depressed mood___tearful/crying

spells____depressed mood___anxiety___hopelessness___panic___other emotions_____

Any medical

conditions?_____
___

Have you ever been hospitalized for a psychiatric issue?_____

Any history of family mental illness?_____
_

Any thoughts of hurting yourself or others?_____
_

Anything you would like me to know as we begin to work together?_____
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_____
_____
_____