Individual Therapy Form

Date: ________________ Name: ____

Home Address: ____

Email Address: ____

Accept Champion Counseling correspondence via email? YES NO

Preferred Contact Phone #: ________________________ Date of Birth: _________________________ Age: _______________________

Employer/Occupation: ____

Relationship Status: Single In a relationship Living with Partner Married Divorced

Children and Ages: ____

Referred by: ____ May I acknowledge them for this referral______________

Describe Previous Therapy: ____

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Medications & Prescribed by:

____

Goals for Therapy: ____

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Emergency Contact: ____ Phone: ____