Linda Goodman Pillsbury, LCSW

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Initial Visit Information

Date: ______________________

Name: ____ Sex: ___Male ___Female

Street Address:
____

City: ________________________________ State: _________ Zip: _____________

Home phone: _________________________ Work phone: ________________________

Cell phone: ___________________________ Fax: ______________________________

Email: _______________________________

Date of birth: _________________________

Other living with you and their relationship with you:

_____________________________________ ___________________________________

_____________________________________ ___________________________________

_____________________________________ ___________________________________

In case of emergency contact:

Name: ________________________________ Relationship to you: __________________

Phones: ____

Therapist communications

My therapist may: ___ call at home ___call on my cell ___call at work ___email me

___ send mail to home ___send a fax to me

I prefer being contacted: __________________________________

Messages may be left: ____________________________________

Referred by: ___________________________ Okay to thank: ___yes ___no

Please describe your main concern(s) prompting you to see me now.

What would you like to be different in your life when you are done with therapy?

Have you ever received psychological or psychiatric counseling before?
___yes ___no When? From whom? Purpose? Results?

Have you ever been prescribed medication for a psychiatric or emotional problem? ___yes
___no When? From whom? Purpose? Results?

Current medications	Dosage	Effectiveness	Prescribing Physician

Alcohol? ___yes ___no How much? _______ How often? _______________
Problem? ___yes ___no Problem in the past? ___yes ___no

Drugs? ___yes ___no What?_________________ How often? _______________
Problem? ___yes ___no Problem in the past? ___yes ___no