

**Carol Battistoni, MA, LMHC**

Psychotherapy and Smoking Cessation

360.510.1550

[carol@thehealingedge.net](mailto:carol@thehealingedge.net)

[www.thehealingedge.net](http://www.thehealingedge.net)

**GENERAL INFORMATION**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone:(home)\_\_\_\_\_

Cell:\_\_\_\_\_

e-mail address:\_\_\_\_\_

Occupation:\_\_\_\_\_

Date of Birth:\_\_\_\_\_ Marital/Significant Partner Status:\_\_\_\_\_

Education Background:\_\_\_\_\_ Learning disabilities:\_\_\_\_\_

Special accommodations I should be aware of?\_\_\_\_\_

Emergency Contact: Name/Relationship/Phone #\_\_\_\_\_

How did you hear about me? (ex. Friend, website, newspaper, etc.)

\_\_\_\_\_

**FAMILY INFORMATION**

Who raised you?\_\_\_\_\_

Are they still living? Age?\_\_\_\_\_

How many siblings?\_\_\_\_\_

Family members with significant illness and/or addiction?

\_\_\_\_\_

Other significant people in your life?:

\_\_\_\_\_

Other significant issues related to family and people in your life?

## **HEALTH AND MEDICAL INFORMATION**

Are you currently being treated by a medical practitioner? Y\_\_\_\_\_ N\_\_\_\_\_

If yes, for what purpose?

Do you have any chronic medical or physical conditions? Y\_\_\_\_\_ N\_\_\_\_\_

If yes, what are they and how do they affect you?

Please list all the prescription and non-prescription medications you are currently taking:

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Have you or someone close to you ever been concerned about your alcohol or drug use?

## **OTHER INFORMATION**

What is your current living situation? (ex. Living alone, with parents, roommates, partner, spouse, children, pets, etc.)

What prior experience do you have with counseling or psychotherapy? What has been helpful and what has not been helpful in the past?

What specifically would you like to accomplish in working with me?

What other information would be of value to me in helping you?