## Ariella Goodwine Fisher, M.S., LMFT Client Information Reunification/Family Therapy

Name:	Today's Date:		
Date of Birth:	email:		
Address:			
City:	State:	Zip Code:	
Phone: cell:		okay to leave a message? yes	no
home:		okay to leave a message? yes	no
work:		okay to leave a message? yes	no
Emergency Contact #1:			_
	Relationship:_		
	Phone #:		
Emergency Contact #2:			
	Relationship:_		_
	Phone #:		_
Employer:			_
Are you currently workin	g with a psychothe	erapist? yes no	

Please list the names and contact information	ı for your Attorney	and your Co-Parent's At-
torney:		

• Attorney		
Phone number:	Email:	
• Spouse's Attorney		_
O Phone number:	Email:	
Length of marriage:		
Names and ages of children:		

How long has the parent/child estrangement or distance been an issue?

Explain the circumstances sur	rrounding the parent/child relationship problem.
Do you have a history of subs	stance abuse and/or dependence? If yes, please describe.
What are your goals/hopes for	r this therapy?
In the past 3 months, have you e sider significant? Please check a	experienced any of the following symptoms at a level that you would con all that apply.
Aggression	Irritability
Anger	Memory problems
Anxiety/Panic	Nightmares
Apathy	Phobias/Fears
Avoidance	Self-destructive relationships
Compulsive Behavior	Self-harm behaviors or impulses (i.e. cutting/burning)
Crying	Sexual acting out

Depression	Sexual dysfunction
Difficulty Concentrating	Substance abuse
Fear	Physical symptoms
Flashbacks	Suicidal thoughts
Guilt/self-blame	Sleep problems (sleeping too much/not enough)
Harm to others/threats to others	Disordered eating symptoms
Hyperactivity	Other:

If you would like to describe any of the above symptoms further, please do so here: