

Ariella Goodwine Fisher, M.S., LMFT
Client Information
Mediation

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 working with a psychotherapist? yes ____ no ____

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

- Attorney _____
 - Phone number: _____ Email: _____

- Spouse's Attorney _____
 - Phone number: _____ Email: _____

Length of marriage: _____

Names and ages of children:

Do you have a history of substance abuse and/or dependence? If yes, please describe.

Have you ever been hospitalized for any mental health concern? If yes please describe and list dates.

Is there a history of domestic violence in your relationship with your co-parent? If yes, please describe.

Describe your current co-parenting relationship.

What are your goals/hopes for this mediation?

In the past 3 months, have you experienced any of the following symptoms at a level that you would consider significant? Please check 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: