Mary Cahir

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Change the Response – Change Starts with You

www.changetheresponse.com ctr@changetheresponse.com

Client Information

Please complete all information – Thank you. Your information is private and secure.

Client Name & **Date of Birth**	

Address	
City	
Postcode/Zip code	
Phone **Mobile/Cell**	

Employment: Occupation/Education	
Are you currently employed?	**Y/N**
Are you a student? **Where?**	**Y/N**

Relationship Status: **Married or Primary Relationship?** **Single?**	**Y/N**
Do you live with this person?	**Y/N**
Do you have children?	**Y/N**
If so, please state their ages:	

Medical Information **Name of Doctor** **Phone**	**Name of Psychiatrist:** **Phone**
Date of last physical exam	**Current Treatment**
Major Illnesses or Operations	**Prescribed medications? Y/N** **Name & Dosage**

Emergency Contact **Name** **Relationship to you**	
Address	
Phone	

Briefly please state your main reason for coming to therapy/counselling at this time.
What do you hope to be different in your life as a result?

Client Signature

Date