EMDR Consultation and Therapy Services
Cossette D. Ahlborn

Intake:
Client Name: _____ DOB: _____
Address: _____
_____
Phone Number: _____ Email: _____
Acceptable to contact you on the above number and leave a voicemail: Yes No

Emergency Contact Name, relationship and phone number:
_____

Occupation: _____ Employer:_____

Please list members of household or immediate family:
Name Relationship Living with: Yes / No
_____
_____
_____

Ethnicity: _____

Health Conditions: _____
_____
_____

Allergies:_____
_____

Current Medications:
_____
_____

Relationship Status: _____
If married how long: _____ Number of Previous Marriages:_____

Substance Use:
Alcohol: _____
Caffeine: _____
Nicotine: _____
Other: _____

Previous Behavioral / Mental Health Therapy: _____
_____
_____
Therapist / Agency: _____ Length of Care: _____

Type of Therapy: _____
What was helpful / not helpful in the previous therapy:_____
_____
_____
Presenting Problem:
_____
_____
_____
_____
Goals for therapy:
_____
_____
_____
_____
Current Symptoms:
_____
_____
_____
_____

Risk assessment:

Are you currently having suicidal thoughts: Yes or No

Have you had suicidal thoughts in the past: Yes or No

Are you currently participating in self-harm behavior: Yes or No

Have participated in self-harm behavior in the past: Yes or No

Is there past/present partner violence in the relationship: Yes or No

If yes to any of the above questions, are you willing to sign a NO-Harm/Violence Contract: Yes or No

Is there anything else you like me to know: _____
_____
_____

Client Signature: _____
Date: _____