

## Client Phone Consultation

A. Canelli MA, LMHC  
1812 E. Madison Ste 206  
Seattle, WA 98122

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Fee Agreement: \$ \_\_\_\_\_

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

DOB \_\_\_\_\_

Pronouns \_\_\_\_\_

Are you living with a Disability? \_\_\_\_\_

If so, please describe \_\_\_\_\_

Address: \_\_\_\_\_  
(Number) (Street) (Apt #)

\_\_\_\_\_  
(City) (State) (Zip code)

Home phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_ Work phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_

Cell phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_ Other phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ E.C. Phone number: \_\_\_\_\_

Primary Care Practitioner \_\_\_\_\_ Number \_\_\_\_\_

How did you hear about me? \_\_\_\_\_

Who referred you to therapy? \_\_\_Self \_\_\_Family/friend \_\_\_Doctor \_\_\_Other: \_\_\_\_\_

Interested in? Individual/Couples/Family/Group therapy: \_\_\_\_\_

Please briefly state why you are seeking therapy at this time.

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What do you hope to get out of therapy?

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Have you ever had a mental health diagnosis?

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Are you currently on any medications for mental health reasons?

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Have you seen a therapist before? If so who/when?

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Per the Washington Administrative Code **246-809-035** you have the right to request no written records be kept of your therapy sessions. If you do not want me to keep notes of your sessions please sign and date here:

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