David Goldstrom, DMin.
Licensed Marriage and Family Therapist

To: New clients of David Goldstrom, DMin, LMFT

Please read and complete the following forms:

- The four-page New Client Information Form – (couples/families: you can either use one form together or fill out separate info forms but no need to duplicate any information)
- The Policies sheet for my practice – we'll discuss this at the beginning of our first session.
- The On Track Outcomes Client Feedback Form (if included – 1 each adult or youth version).

If you complete these forms after our appointment and I'm busy with another patient, you can leave them outside my office, on the clipboard, with the forms turned down.

Thank you,

David Goldstrom

110 Allens Creek Road, Rochester, NY 14618
Phone: 585.473.2671 Fax: 844.267.5857 Website: www.davidgoldstrom.com

New Client Information

(Please provide the following information so I can better work with you.)

Today's Date ____/____/____

Name	*First*		*MI*	*Last*		
Address						*Apt#*
City			State		Zip	
Gender	☐ M ☐ F	Birth Date	____/____/_____		SSN	- -
Relationship Status	☐ Single ☐ Married ☐ Together ☐ Separated ☐ Divorced ☐ Widowed					
Emergency Contact	*Name*		*Relationship*		*Phone* ( ) -	
Primary Care Physician	*Name*				*Phone* ( ) -	

Contact Information: Please provide your contact information. In the box to the right of "Pref," please mark "1" for your first choice of how to be contacted, "2" for your second choice, etc. If I should not contact you by this method, please mark "NO"

Home Phone	*Pref*	( ) -	Work Phone	*Pref*	( ) -
Cell Phone	*Pref*	( ) -	E-mail	*Pref*	

Employment /School Information

Employment	o Full-Time o Part-Time o Not Employed o Student o Disabled				
Employer or School	*Address*				
City		State		Zip	

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Family Information:

Spouse or Partner's Name	Age	Sex	Previous Marriages or relationships	Dates
Time together (yrs/months)				

Children at home – Names	Age	Sex	Children not currently with you – Names	Age	Sex
1st					
2nd					
3rd					
4th					

Reason(s) for seeking therapy at this time: Please check all that apply (and if you wish, you may write in "other" in your own words:

☐ Depressed Feelings
☐ Anxious Feelings
☐ Guilt Feelings
☐ Anger Issues
☐ Grief
☐ Spiritual Problems
☐ Religious Doubts
☐ Loss of Faith
☐ Loss of Hope
☐ Loss of Love
☐ Loss of Meaning
☐ Loneliness
☐ Fearfulness
☐ Despair
☐ Self-Esteem Issues
☐ Self-Doubt Issues
☐ Loss of Self Respect
☐ Sleeping Problem
☐ Eating Problem
☐ Poor Physical Health
☐ Headaches
☐ Fatigue
☐ Mid-Life Issues
☐ Aging Issues
☐ Thinking Confused
☐ Poor Memory
☐ Trouble with Concentration
☐ Racing Thoughts
☐ Suicidal Feelings /Thoughts
☐ Trouble with Spouse / Partner
☐ Trouble with Children
☐ Trouble with Parents
☐ Trouble with Work/School
☐ Drug/Alcohol use Problem
☐ Sexual Problem
☐ Abuse: Physical, sexual, emotional
☐ Legal Issues
☐ Financial Concerns

_____

_____

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Please state in your own words any other reasons for seeking counseling/therapy at this time:

_____

_____

How were you referred to me? _____

May I thank them for the referral? ☐ Yes ☐ No

Have you been in Therapy or Counseling before? ☐ Yes ☐ No

If so, when and with whom? _____

Have you ever been diagnosed with Mental Health problems? ☐ Yes ☐ No

What was your diagnosis (if known) and what treatment have you received and with whom?

_____

Do you use:

☐ Tobacco; ☐ Caffeine; ☐ Alcohol; ☐ Rx Drugs off prescription; ☐ Non-Rx Drugs; ☐ Street Drugs

Serious illnesses and hospitalizations:

_____

Your estimation of your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

List any medications you are currently taking, dosage, and the reason for their use:

_____

Current serious illnesses and hospitalizations in other family members:

_____

Religious Affiliation, if any:

_____

Religious Preference, if any: Membership: Where do you attend?

_____

Role of Spirituality in your life:

_____

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Family of Origin (Self)

Name (Father, Mother, Siblings)	Age	Sex	Residence	Occupation	Deceased (date and cause)

Family of Origin (Spouse or Partner)

Name (Father, Mother, Siblings)	Age	Sex	Residence	Occupation	Deceased (date and cause)

What do you hope to achieve in counseling/therapy? What are your goals and expectations?

Is there anything else you would like to share about yourself that will help in our work together?

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Practice Policies

Privacy: As a psychotherapist, your privacy is of the utmost importance to me. Our communications (and even the fact that you have come to see me) are confidential. My policy is to release your information only:

- to you, or as explicitly authorized by you
- as necessary for your treatment (e.g. managing an emergency)
- in rare instances, as otherwise required by law (e.g. as a mandated reporter of child abuse)

If it is important to you that I communicate with you in particular ways (e.g. not to leave a message at your work number), please be sure to let me know.

With some of my patients, I make video recordings of sessions, but only with prior discussion and written consent.

My privacy policy is available on the web site (www.davidgoldstrom.com) and I will provide you with a printed copy on request. If you have any questions or issues about privacy, confidentiality, or how I manage your information, please speak to me or contact me.

Signed: _____ Date:_____

Cancellation: If you're unable to keep your appointment, please give me as much advance notice (in person or by telephone) as you're able to. If the notice is less than 24 hours, you will be responsible for the appointment charge. Please note that insurance does not cover the cost of missed or canceled appointments. With advance notice, I am sometimes able to reschedule an appointment without charge.

Signed: _____ Date:_____

E-mail and Phone Calls: I am available by email, but email contact with me is not completely reliable. In the event of an emergency or anything requiring a rapid response, call me rather than emailing. If you email me and don't hear back within a few days, please contact me again, either by phone or email.

Because email is not encrypted, it is not possible to absolutely guarantee its privacy. By emailing me, you are consenting to me sending you email communication that may contain protected information.

Signed: _____ Date:_____

Incidental Contact: I sometimes run into patients by chance, e.g. on the street or at a movie theater. Because of confidentiality, I do my best to leave it up to you whether to acknowledge these encounters or not. It's OK with me when patients greet me, and it's OK with me when patients choose to ignore me in these situations.

Signed: _____ Date:_____

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