

New Source Counseling Centers

Initial Contact Form

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

Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Main Concerns: Please briefly describe what issues are bringing you to counseling today.

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How long have you been experiencing these concerns? \_\_\_\_\_

What have you tried to do to change the situation and how did these efforts work for you?

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What would you like to accomplish in counseling? How would you like things to change for you? \_\_\_\_\_

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