



Wendy K. Berger, MA, LPC
Transformational Counseling and NET for Adults and Children

CONFLUENCE WELLNESS CENTER, PC

1776 South Jackson St., Ste. 418, Denver, CO 80210 • 303-394-4204 • www.confluencewellness.com

Name: _____ Age: _____

Today's Date: _____ Date of Birth: _____

Address: _____ Telephone: _____
(street) (home)

_____ (city, state, zip) _____ (work)

Emergency Contact Information (name, relationship, phone #): _____

Your Email address _____

Name of Partner/Wife/Husband _____

Names of Children and Ages: _____

List your siblings in rank order of their birth, including their age: _____

Name of Present Employer: _____

Address: _____

Length of Employment in Present Position? _____

Present Health Concerns: _____

Medications? Yes No

If yes, please list all medications: _____

Hospitalizations? Yes No

If yes, please list dates and reasons: _____

Previous Counseling? Yes No

If yes, please list dates and reasons: _____

Was it helpful? _____

Do you drink alcohol or smoke marijuana? How often? _____

What is your concern and reason you are here today? _____

Please tell me your mental, emotional and/or spiritual goals for our work _____

On the back side of this form, or a separate sheet of paper, please draw a time line of your life with any significant physical, mental, emotional, or spiritual challenges you have experienced.