

**Inspired Healing**  
**Jim Soward LPC, LSAC**  
**5350 E. Broadway, Suite 108 Tucson AZ 85711**  
**(520) 584-0343**

Name \_\_\_\_\_ DOB \_\_\_\_\_

**Information Sheet**

To help me serve you better, your cooperation in completing this questionnaire will be helpful in planning our services for you.

Address: \_\_\_\_\_

Street Address

\_\_\_\_\_

City

State

Zip Code

Email Address

Please indicate best contact #

Telephone(s): \_\_\_\_\_

home

work

cell

Age \_\_\_\_\_ Marital Status: \_\_\_\_\_ #of children/ages \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Student? \_\_\_\_\_

Place of employment: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Emergency Contact:

\_\_\_\_\_

Name

Phone

Relationship

How were you referred us? \_\_\_\_\_

Briefly describe your reason for seeking help:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever received psychiatric or counseling before? \_\_\_\_\_ If you have, please give dates and briefly explain what you worked on and results:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**MEDICAL INFORMATION**

When were you last examined by a Physician? \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Phone \_\_\_\_\_

List any major health problems for which you currently receive treatment:

\_\_\_\_\_

List any medication you are now taking:

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

others (vitamins, supplements) \_\_\_\_\_

**PROBLEM LIST**

Please check any of the following that apply to you:

- Nervousness      Depression      Guilt      Shame      Crying Spells
- Shyness      Sexual Problem      Fears      Self-Control      Separation/Divorce
- Suicidal Thoughts      Drug Use      Alcohol Use      Finances      Anger
- Sleep problems      Anxiety      Unhappiness      Stress      Work Problems
- Panic Attacks      Headaches      Memory      Lack of Ambition      Loneliness
- School Problems      Concentration      Career Choices      Parenting
- Health Problems      Tiredness/ Low Energy      Grief      Weight Gain/Loss
- Appetite      Spiritual Issues      Legal Matters      Overwhelming Debt

Please add any additional information which you feel may be useful to your therapist:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_