

**Leslie Vriesman, M.S., LMFTA**

The Mending Place  
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**Client Information**

Today's Date: \_\_\_\_\_ Referral Source: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ M \_\_\_ F \_\_\_

Occupation: \_\_\_\_\_

Marital status: \_\_\_\_\_

Spouse/partner's name: \_\_\_\_\_ Age: \_\_\_\_\_

Other family members attending sessions:  
\_\_\_\_\_

Others living in the home (please give names and ages): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Phone: (home) \_\_\_\_\_ Okay to leave message? \_\_\_\_\_

(cell) \_\_\_\_\_ Okay to leave message? \_\_\_\_\_

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

How would you prefer I contact you? \_\_\_\_\_

Emergency contact (name and phone number):  
\_\_\_\_\_

Relationship to client: \_\_\_\_\_

Briefly describe your main reason(s) for seeking therapy at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: Please provide name, dosage, date meds began and what prescribed for?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name/Phone number of your primary care physician: \_\_\_\_\_  
\_\_\_\_\_

How would describe your alcohol or drug consumption? List substances used and how often:

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Are you concerned about your physical safety? If so, please explain. \_\_\_\_\_

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Please circle any that might apply now as issues for you:

Alcohol use	Career	Thoughts
Anxiety	Compulsive habits	Unhappiness
Concentration	Crying	Children
Depression	Decisions	Communication
Drug use	Fears	Divorce
Eating Issues	Flashbacks	Finances
Headaches	Grief/loss	Gambling
Health	Guilt	Intimacy
Hyperactivity	Hopelessness	Isolation
Impulsiveness	Inferior feelings	Legal matters
Memory	Loneliness	Marriage
Mood swings	Pain	Parents
Nervousness	Panic	Relationships
Sexual problems	Phobias	Religious matters
Sleep problems	Sadness	School
Stress	Self- control	Separation
Tension	Self-injury	Sexual identity
Tiredness	Shyness	Work
Anger	Suicidal thoughts	

Other: \_\_\_\_\_

Please add any additional information that you may feel useful in helping you:

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