

**BobCat Consulting,**

Catriona O'Curry, M.A.

Robert Harris, M.A.

529 E Roger Rd

Tucson, AZ, 85705

(520)-822-4982

**PRIVATE CLIENT INFORMATION**

TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_ AGE \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

SINGLE       MARRIED: HOW LONG? \_\_\_\_\_

COUPLED, NOT MARRIED: HOW LONG \_\_\_\_\_

SEPARATED       DIVORCED: HOW LONG? \_\_\_\_\_

WIDOWED       PREVIOUS MARRIAGES: HOW MANY? \_\_\_\_\_

PARENT OR  
SPOUSE/PARTNER \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

ZIP \_\_\_\_\_

CHILDREN:

NAME \_\_\_\_\_

( ) MALE ( ) FEMALE

NAME \_\_\_\_\_

( ) MALE ( ) FEMALE

NAME \_\_\_\_\_

( ) MALE ( ) FEMALE

\_\_\_\_\_  
**I HEREBY ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT OF SERVICES RENDERED.**

X \_\_\_\_\_

Signature of Responsible Party

PLEASE DESCRIBE YOUR CURRENT SITUATION:

WHAT DO YOU HOPE TO ACCOMPLISH THROUGH WORKING WITH US?

PLEASE DESCRIBE YOUR CURRENT PHYSICAL HEALTH:

DO YOU SMOKE? YES/NO \_\_\_\_\_ SPOUSE/PARTNER? YES/  
NO

DO YOU DRINK ALCOHOL? YES/NO \_\_\_\_\_ SPOUSE/  
PARTNER? YES/NO

DO YOU USE ANY OTHER SUBSTANCES? Y/

N \_\_\_\_\_ SPOUSE/ \_\_\_\_\_

(i.e. MARIJUANA, COCAINE, ETC.)

PARTNER YES/NO

ARE YOU TAKING ANY MEDICATION? Y/N \_\_\_\_\_ SPOUSE/

PARTNER YES/NO

DO YOU HAVE ANY TROUBLE SLEEPING? Y/N \_\_\_\_\_ SPOUSE/

PARTNER YES/NO

RECENTLY GAINED/LOST WEIGHT? HOW MUCH? \_\_\_\_\_ SPOUSE/

PARTNER HOW MUCH?

ARE YOU CURRENTLY BEING TREATED FOR ANY

PSYCHOLOGICAL ILLNESS? YES/NO \_\_\_\_\_ SPOUSE/PARTNER

PLEASE DESCRIBE:

NAME OF PHYSICIAN:

LAST PHYSICAL EXAM:

HOW WOULD YOU DESCRIBE YOUR SPIRITUAL HEALTH? :