Tara Alder New Client Information Form

Date: _____

Name(first & last): _____

Home Phone: _____ Cell Phone: _____

Best time to call?_____ Is it okay to leave messages at these numbers? □ Yes □ No
If no, please list which number it is okay to leave a message?_____

E-Mail Address: _____

Address: _____

_____
(City) (State) (Zip)

How long have you been living at this address? _____

Occupation: _____

Date of Birth: _____

For appointment scheduling, what are the best:
Times of day: _____
Days of the week: _____

Marital Status: □ Never Married □ Married □ Domestic Partnership □ Divorced □ Widowed

Emergency Contact Information:
Name: _____
Relationship: _____
Phone: _____

Do you have pets? □ Yes □ No
If yes, please list: _____

In what areas of your life would you like to improve?

- ☐ Finances
- ☐ Time
- ☐ Romantic relationships
- ☐ Friendships
- ☐ Family
- ☐ Health
- ☐ Emotion healing
- ☐ Self-worth
- ☐ Manifestation

What are the top 3 things you want to receive support or guidance on?

#1_____

#2_____

#3_____

Are there any areas in your life where you feel stuck? If yes, explain:

_____

_____

_____

_____

Are you aware of your limiting beliefs?

- ☐ Yes
- ☐ No

Do you have limiting beliefs you want to remove from your life? If so, what are they?

_____

_____

_____

Do you have traumas that are holding you back in life?

_____

_____

_____

Do you have goals? If so, what are they?

_____

_____

_____

Please list the names and relationships of the five most important people in your life:

1. _____
2. _____

3. _____
4. _____
5. _____

Education: _____

How would you rate your overall physical health? □ Excellent □ Great □ Good □ Fair □ Poor

Do you have any sleep problems? □ Yes □ No
If yes, please describe:_____

Are you dealing with any past or current addictions? □ Yes □ No
If yes, please describe: _____
_____
_____

How would you rate your overall mental and emotional health?
□ Excellent □ Great □ Good □ Fair □ Poor

Have you had any issues with Depression, Anxiety, or ADD/ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)? □ Yes □ No
If yes, please describe:_____
_____

Are you currently seeing a therapist? □ Yes □ No
If yes, please describe what issues your addressing in therapy:
_____
_____
_____

Are you currently taking any medications? □ Yes □ No
If yes, please list:
_____
_____
_____

Are you usually: □ Early □ On Time □ Running Late

Do you exercise regularly? □ Yes □ No
If yes, please describe what you do and how often:
_____
_____
_____

How often do you watch television?

Are there any areas in your life where you feel stuck? If yes, explain:

What are the top 3 things you want help with?

Do you practice self-care? If yes, explain:

What are you passionate about?

What are your favorite hobbies and sports?

What do you do for fun?

What is your spiritual orientation?

When you treat yourself, what are things you like to do?

What is your idea of a perfect vacation?

_____
_____
_____

How did you hear about me?

_____
_____