Jana L. Ekdahl MA, LMHC
Psychotherapist

Transformational Unfolding

INITIAL ASSESSMENT INFORMATION

Name: _____ Date Of Birth: _____

Address: _____

City/ Zip: _____ Gender: _____

Phone Number: (H)_____ (W)_____

Emergency Contact: _____ Tel.: _____

Referral Source _____

Medical Provider: _____

Tel: _____ Fax: _____

Medical Conditions/Allergies _____

Medications: _____

Usual Occupation: _____

If you are working, are you satisfied with your work? _____

If you are in school, are you satisfied with school? _____

Group affiliations? _____

E-mail address _____

Relationship concerns, i.e.: partner, spouse, friends, co-workers, acquaintances, etc.?

Comments: _____

10016 Edmonds Way, Suite C Edmonds WA 98020 206/ 355-2294
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