Iris Avishai Cohen

LCSW-R | Client information

A little about you

Please complete what you can. We can go over any questions when we meet.

About you

Full name

Name you go by

Date of birth

Pronouns (optional)

Street address

City, state, ZIP

How to reach you

Phone

Email

Preferred contact method

Choose an option

May I leave a voicemail?

Choose an option

Anything I should know about contacting you?

Emergency contact

Contact name

Relationship to you

Contact phone

Please save or print your completed form and bring it to our first session.

What brings you to therapy

Share as much as you would like. We will have time to talk more in person.

I am interested in

Choose an option

Date completed

What brings you to therapy at this time?

What would you like us to work on together?

Have you been in therapy before? What was helpful?

A little more background

Other healthcare providers you are currently working with

Medications or health concerns you would like me to know about

Anything else you would like to share