Mark Zentner, Ph.D. Licensed Psychologist 8701 Shoal Creek #403 Austin, TX 78757 512-965-9895

## **Confidential Client Information**

Name:		
Street Address:		
City/State/ZIP:		
Home Phone:	Cell phone:	
Occupation:	Employer:	
Gender: Date of Birth:	Age:Relationshi	p Status:
Ethnic/Racial Background:		
Insurance Company:	Group/Policy Number	:
Individual Insurance Policy Number:		
Name of physician:		
If you have previously participated in mental for seeking treatment at that time, when treat whether or not you felt is was helpful:	ment began, duration of treatn	nent, and
Describe any current health concerns:		
List medications you currently take:		
Please briefly describe the concern(s) which	led you to begin therapy at thi	s time:

	Self-esteem, self-confidence Anxiety, worry, fears Depression Sexual concerns Angry, hostile feelings Traumatic experiences Aggression toward others Suicidal thoughts/behaviors Stress Self-control issues Health problems Discrimination related to identity Exploration of aspects of identity		Family conflicts Friendship conce Relationship/man Shyness, being a Loneliness Procrastination of Eating or appetit Alcohol or drug Sleep problems Parent-child prob Work/career con Grief/loss concer	erns rital concerns ssertive or motivation e problems use issues blems cerns
	Other:  members of your immediate family or, children) and others who are relev	(include	e parents, siblings,	- IS:
Name		·		Deceased?
Name		·		
Name		·		