Trust 2 Believe
Sogol Philipson, LCSW | California LCSW #66853
4199 Campus Drive, Suite 550 | Irvine, CA 92612 | Telehealth

New Client Questionnaire

Please complete what you can. You may leave a question blank and discuss it privately with your therapist. This information is collected for clinical care; use a secure intake system rather than ordinary website email.

Contact details

Full legal name

Preferred name / pronouns (optional)

Date of birth

Address / city / state / ZIP

Phone

Email

Emergency contact name / relationship / phone

Reason for seeking care

Main concerns (select any)

- [ ] Relationships
- [ ] Anxiety
- [ ] Depression

Additional concerns

- [ ] Life transitions
- [ ] Stress
- [ ] Grief

What would you most like help with?

What changes would tell you therapy is helping?

Previous care and current health



New Client Questionnaire

Have you previously received mental health treatment?

☐ Yes ☐ No

Prior therapy / hospitalization (optional details)

Current medications and relevant health conditions

Current healthcare or psychiatric providers (optional)

Safety screening

If you are in immediate danger, do not use this form; call 911 or 988 as appropriate.

Are you currently concerned you may harm yourself or someone else?

☐ Yes ☐ No ☐ Prefer to discuss

Anything the therapist should know to help you feel safe?

Lifestyle and supports

Important relationships, family or living situation

Sleep, appetite, substance use or stress concerns (optional)

Strengths, coping skills, community or spiritual supports (optional)

Anything else you would like the therapist to know?

Acknowledgment / signature

Client full name



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Client signature (type name if accepted by your secure e-signature workflow)

Date

Electronic signatures should be collected through an approved system that records consent and audit details.