Maya Geyer, LCSW, RPP, LMT
Integrated Psychotherapy & Bodywork
www.integratedbodymind.com
917.545.0937

Name:_____

Address:_____

Phone Number: _____ May I leave a message?_____

Email address:_____ May I email you?_____

Birthdate:_____

In case of emergency:_____ Phone (_____)_____

Referred by:_____

24 Hour Cancellation Policy: I agree to give at least 24 hours notice of cancellation. I agree to pay the session in full if I need to cancel less than 24 hours in advance.

Signature_____Date_____

Maya Geyer, LCSW, RPP, LMT
Integrated Psychotherapy & Bodywork
www.integratedbodymind.com
917.545.0937

Please describe what brings you to seek therapy and/or bodywork now:_____

_____

_____

_____

_____

_____

What are your current goals for therapy and/or bodywork?_____

_____

_____

_____

_____

Have you had previous psychotherapy? YES NO

If so, when and for how long?

_____

Please describe your previous psychotherapy experience:

_____

_____

Are you currently on prescription medication? YES NO

Please list:_____

Have you ever been prescribed psychiatric medication? YES NO

Please list:_____

Have you ever had bodywork? YES NO

If so, what modalities and what was your experience?_____

_____

_____

Are You Now Under a Doctor's Care? YES NO

If so, Doctor's name and phone number: _____

Maya Geyer, LCSW, RPP, LMT
Integrated Psychotherapy & Bodywork
www.integratedbodymind.com
917.545.0937

Reason for Doctor's Care: _____

Please check all that apply and provide brief explanation:

Difficulty concentrating_____

Sleep disturbances _____

- Difficulty falling asleep_____
- Difficulty staying asleep _____
- Not enough sleep _____
- Sleeping too much _____
- Difficulty waking up _____

Weight loss _____

Weight gain _____

Decrease in pleasurable activities _____

Decrease in energy level _____

Social isolation _____

Excessive crying _____

Mood swings_____

Accelerated heart beat/Palpitations_____

Shortness of breath_____

Dizziness_____

Gastrointestinal symptoms_____

Headaches_____

Chest pains_____

Sweating_____

Nausea_____

Panic reactions_____

Significant surgeries or medical conditions _____

_____

Areas of pain or tension _____

Maya Geyer, LCSW, RPP, LMT
Integrated Psychotherapy & Bodywork
www.integratedbodymind.com
917.545.0937

History of medical/physical experiences (pre/perinatal trauma, surgeries, serious illness, fevers, dental surgeries, anesthesia, hospitalizations, falls, car accidents, impacts), including age/year:

_____

_____

_____

_____

_____

Do you drink alcohol? YES NO If so, how often?_____

Do you use illegal drugs? YES NO If so, what and how often?_____

Are you currently in a relationship? YES NO If so, for how long?_____

How would you describe your current relationship?_____

Do you have any children? YES NO Ages:_____

Are you currently employed? YES NO If so, for how long? _____

What do you do? _____

Do you enjoy your work? YES NO Is it stressful? YES NO

Do you exercise? YES NO

If so, what type?_____ How frequently?_____

What do you do for fun_____

_____

Do you consider yourself to be spiritual or religious? YES NO

If so, please describe your spiritual or religious beliefs:

_____

_____

_____

What do you consider to be some of your strengths?_____

_____

_____

_____

Maya Geyer, LCSW, RPP, LMT
Integrated Psychotherapy & Bodywork
www.integratedbodymind.com
917.545.0937

What do you consider to be some of your areas in need of growth and attention? _____

_____

_____

_____

_____

Please provide any additional information that may be helpful:_____

_____

_____

_____

_____