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Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell/Work/Other Phone: _____ May we leave a message? Yes No

Email: _____ May we leave a message? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Marital Status: _____

Referred By (if any): _____

History

Have you previously received any type of speech/cognitive health services? _____

If Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? Yes No If yes, please list:

General Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Are you currently experiencing any chronic pain? No Yes

If yes, please describe: _____



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Personal Goals for therapy/coaching

1. _____
2. _____
3. _____
4. _____
5. _____