Doreen Bridgman MS,CCC,SLP
2362 Apple Ridge Circle
Manasquan, NJ 08736
doreen@thecognitivecoach.net
732-977-7381

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: _____
Martial Status: __ Never Married __ Domestic Partnership __ Married __ Separated __ Divorced __ Widowed
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._____