Dayna Burnett, Ph.D.
4103 Marathon, Suite 200
Austin, TX 78756

Confidential Client Information

Date: _____

Name: _____ Social Security #: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Sex _____ Date of Birth _____ Age _____ Marital Status _____

Ethnic Background _____ Name of physician _____

Insurance Company _____ Group/Policy Number _____

Name(s) of previous therapist(s) and dates seen: _____

_____

Describe any health concerns: _____

_____

List drugs/medications you presently use: _____

Referred by: _____ Phone _____

Please describe briefly the concern(s) that bring you here: _____

_____

_____

_____

_____

Please check any of the following items which concern you:

____ Self-esteem, self-confidence
____ Anxiety, nervousness, fears
____ Depression
____ Sexual concerns
____ Angry, hostile feelings
____ Traumatic experience
____ Physical distress
____ Eating or appetite problems
____ Alcohol or drug problems
____ Sleep problems
____ Parent-child problems
____ Other: _____

____ Family conflicts or pressures
____ Friendship conflicts
____ Relationship/marital concerns
____ Shyness, being assertive
____ Loneliness
____ Procrastination or motivation
____ Gay/Lesbian issues
____ Suicidal feelings or behaviors
____ Stress
____ Self-control
____ Health problems
____ Work or career concerns

Please put a *second* check next to those that are of *particular* concern to you right now.

Please list the members of your immediate family (include parents, siblings, spouse/partner, children, and all others in your home):

Name	Relationship	Age	Occupation	Education