

Ultreya Therapy, Inc.

Michelle E. Wade (she/her/hers)
Ed.D., LPC-S (VA), NCC, ACS, BC-TMH

Demographic Information

Name: _____

Legal Name (if different): _____

Pronouns: _____

Gender Identity: _____

Sexual Orientation: _____

Race/Ethnicity: _____

Date of Birth/Age: _____

Are you in a relationship currently: _____

How would you describe that relationship: _____

Are you currently employed: _____

Do you have any medical conditions/allergies I should be aware of: Yes No

If yes, what are they: _____

Are you on any medication: Yes No

If yes, what medications: _____

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Have you ever seen a mental health professional before: Yes No

If yes, what for and when: _____

What are your concerns that are bringing you in to counseling: _____

What are three goals you have for counseling: _____
