



PSYCHOTHERAPY WITH DR. LINDA HOFFMAN

Phone Consultation Request

Full name: _____

Best phone number to reach you: _____

Email address¹: _____

Name of person who referred you (if not referred, leave blank): _____

I currently reside in (select all that apply): California New York Other

Are you a professional in the entertainment industry? Yes No

How did you first hear about me? Insurance company Google search
 Psychology Today Therapy Den Zencare Other

Which services are you seeking? (Select ALL that apply.) Brief psychotherapy
 Complex psychotherapy "Life Support" Trauma Therapy
 Exposure & Response Prevention

What health insurance provider(s) do you have? _____

Please select the option that best describes how you would like to use your insurance benefits for services.

- I need to see a therapist who is in-network with my insurance.
- I prefer to see a therapist who is in-network with my insurance, but I can also pay for out-of-network services if some portion is covered by insurance.
- Insurance coverage is not a primary factor in seeking services.
- I prefer not to use my insurance even if the services are covered or the provider is in-network.

Availability (REQUIRED)										
WEEKLY APPOINTMENT: Please select ALL the days/times that you are available for a weekly appointment. (Please note: All times are listed in Pacific Time.)										
	10AM	11AM	12PM	1PM	2PM	3PM	4PM	5PM	6PM	7PM
Monday										
Tuesday										
Wednesday										
Thursday										

¹ By providing your email address, you consent to being contacted via email.

Please identify any concerns that prompted you to seek treatment. (Select all that apply.)

- Addictions (sex, gambling, video games, etc.)
- ADHD or learning problems
- Alcohol or drug concerns
- Anxiety, fears, or nervousness
- Career concerns
- Dieting, weight concerns
- Discrimination, harassment
- Identity/sense of self
- Loss, grief, or death
- Low mood, sadness
- Obsessions and/or compulsions
- Procrastination
- Relationship issues (family, friends, romantic partners)
- Seeing/hearing things others do not
- Sexuality concerns
- Stress or tension
- Self-harm (self-injury or thinking about suicide)
- Sexual abuse or assault
- Other (please specify): _____