



**CENTER FOR VETERANS IN TRANSITION (CVIT)**  
**CENTER FOR HEALING AND EMOTIONAL WELLNESS (CHEW)**  
 "WAKING UP TO OUR OWN TRUE SELVES"

Steve Zappalla, LPC, ACS, NCC, CSAC  
 11250 Roger Bacon Dr, Unit #2,  
 Reston, VA 20190  
 571-271-7284

Name(s): \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address:

\_\_\_\_\_

Address

City

State

Zip code

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Name of Spouse / Life Partner \_\_\_\_\_

Name and Age of children: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Email: \_\_\_\_\_

*By providing this information you give The Center for Veterans in Transition permission to communicate with you directly or leave messages/texts, unless otherwise specified.*

What made you seek out therapy? \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Conditions:(past/current) \_\_\_\_\_

Have you been to therapy before? \_\_\_ NO \_\_\_ YES If Yes, When: \_\_\_\_\_

Previous mental health diagnosis or emotional issues \_\_\_\_\_

Medication(s) taking? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_ NO \_\_\_ YES If Yes When: \_\_\_\_\_

Have you recently considered committing suicide? \_\_\_ NO \_\_\_ YES

**Emergency Contact:** \_\_\_\_\_ Phone number: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

How did you find us? \_\_\_\_\_

How do you intend to pay for services? \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_