

GENERAL INFORMATION

Name: _____ **Today's Date** _____
Address: _____ **City:** _____ **State:** ____ **Zip:** _____
Home Phone (____) _____ **Cell #** (____) _____ **Work Phone** (____) _____
E-mail Address (please print clearly): _____
Date of Birth: _____ **Age:** ____ **Marital/Partnership Status:** _____ **Gender:** ____ F ____ M
Educational Background: _____ **Occupation:** _____
Any Known Learning Disabilities: _____
Emergency Contact: Name/Relationship _____ **Phone(____)** _____
Who referred you to this office? _____

FAMILY SYSTEM INFORMATION

	Name	Living?	Age	Marital Status	Illness/Addiction	Other Issues
Father						
Mother						
Other/Parent						
Siblings						
Spouse/Partner						
Spouse/Partner						
Children						
Grandparents						
Closest Friend						

HEALTH AND MEDICAL INFORMATION

Are you currently being treated by a physician? ____yes ____no

If yes, for what purpose?

Date of your last completed physical examination: _____

Do you have any chronic medical or physical conditions? ____yes ____no

If yes, what are they and how do they affect you?

Please list all prescription and non-prescription medications you are now taking:

Please note any significant current or past health issues:

OTHER INFORMATION

What is your current living situation? (e.g, living alone, with parents, roommates, partner, spouse, children, etc.)

What prior experience do you have with counseling or psychotherapy?

What other information do you think would be of value to me in providing services to you?

What, specifically, would you like to accomplish as a result of working with me?