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 you 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?