Name: _____ Date: _____

Date of Birth: _____ Age: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Cell _____

Work Phone: _____ Employer: _____

May I call you and leave messages at home? Yes ☐ No ☐ On your cell? Yes ☐ No ☐ At Work? Yes ☐ No ☐

Marital status: S ☐ M ☐ D ☐ W ☐ LT ☐ Married how long? _____ Previously Married? Yes ☐ No ☐

Spouse: _____ Date of Birth/Age _____

Children: _____ Date of Birth/Age _____ Step/Bio/Adopted _____

_____ Date of Birth/Age _____ Step/Bio/Adopted _____

_____ Date of Birth/Age _____ Step/Bio/Adopted _____

_____ Date of Birth/Age _____ Step/Bio/Adopted _____

MEDICAL HISTORY

Are you currently experiencing physical problems or medical problems (e.g. headaches, body aches, stomach problems)? Yes ☐ No ☐

If yes, please explain: _____

Please list any learning disabilities: _____

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? Yes ☐ No ☐ If yes, when? _____ Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

Have you ever been diagnosed with or treated for any type of mental illness? Yes ☐ No ☐ If yes, what? _____

Has anyone in your family been diagnosed with or treated for any type of mental illness? Yes ☐ No ☐ If yes, what?

MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today? _____

What do you hope you will gain from counseling? _____

EMERGENCY CONTACT (Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____

Address: _____ City, State, Zip: _____