

PERSONAL DATA

Date: _____ How did you find us: _____

Client Name _____ Male _____ Female _____ Ethnicity (optional) _____

Address _____ City _____ Zip Code _____

E-Mail _____ Phone: Home _____ Work _____ Cell _____

Which one would you prefer your therapist to try first? _____ May he/she leave a message at hm? _____ wk? _____ cell? _____

Age _____ Birthdate _____ Education/Highest grade completed? _____

Marital Status _____ Satisfaction re: marital status _____ Length of Marriage: _____

Number, ages, & gender of children _____ With whom do they live? _____

Occupation _____

Work Address _____ City _____ Zip Code _____

Previous Occupations _____

What type of health insurance do you have: HMO _____ PPO _____ POS _____ No insurance: _____

(We will not file health insurance claims for you but want to make sure that we provide you with the appropriate documentation.)

Would you like spirituality/religious issues to be a part of your therapy? Yes / No / Don't Know

Medication and Substance History: Please indicate with an "X" how often you use any of the following:

	Daily	Frequently	Occasionally	Never
Appetite Suppressants	_____	_____	_____	_____
Sedatives/Tranquilizers	_____	_____	_____	_____
Sleeping Pills	_____	_____	_____	_____
Stimulants	_____	_____	_____	_____
Narcotics	_____	_____	_____	_____
Pain Killers	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Hallucinogens	_____	_____	_____	_____
Blood Pressure Medicine	_____	_____	_____	_____
Heart Medicine	_____	_____	_____	_____
Birth Control	_____	_____	_____	_____
Other (please specify)	_____	_____	_____	_____

Please list other medications _____

Date of last medical examination _____ with your Primary Care Physician? _____ or Specialist? _____

Have you ever had any previous counseling or psychotherapy? Yes / No If yes, when? _____

Length? _____ Was therapy successful? Please comment: _____

_____ Have you ever been hospitalized for psychiatric reasons? Yes / No

If yes, when? _____ Length of hospital stay? _____

Contact in case of emergency: _____ Phone number _____

Relationship to you: _____

In your words, what brings you to therapy today?

Client Signature _____ Date _____

Therapist Signature _____ Date _____