Welcome. Please take the time to complete both pages of this form to assist us as we begin our work together. All information provided here is confidential and will not be released without your written approval. Thank you.

Please Print

Last Name	First Name	MI	Today's Date	
Residence Address		City	State	Zip
Home Phone ( )	Cell Phone ( )	Date of birth	Age	Sex
Can I leave a message at the above phone numbers? Yes / No (circle one)				
Employer Name	Work Address	City	State	Zip
Work Phone ( )	Occupation		Referred By	
Did your physician or psychiatrist refer you? Yes / No Name		Phone ( )		
Physician's Information Name:	Address:	Phone ( )		

Your parents: Mother Living? Yes / No		Father Living? Yes / No	
Name	Age	Name	Age
If deceased, yr of death _______		If deceased, yr of death _______	
Your family: Sisters Name	Age	Brothers Name	Age

Check one Single _____ Married _____ Separated _____ Divorced _____ Remarried _____

Spouse's Name	Age	Occupation	
Spouse's Employer	Work Address		Work Phone ( )
Spouse's Mother Living? Yes / No Name	Age	Father Living? Yes / No Name	Age
Spouse's Family: Sisters Name	Age	Brothers Name	Age

Your Children

Name	Age	His	Hers	Ours	Adopted	Where Residing
1						
2						
3						
4						
5						

(Check One: His / Hers / Ours / Adopted)

Other people living with you	Relationship
Have you been in therapy before? Yes / No If yes, with whom, when & where?	
Are you in school now? Yes / No Highest grade completed Degree	
In case of emergency contact Relationship	Day Phone ( ) Night Phone ( )
List major medical conditions List medications you are currently taking	
Have you or anyone in your family ever had (have) a problem with the following: Alcohol _______ Drug _______ Gambling _______ Sex Addiction _______ If so, please explain briefly:	
I have _______ have not _______ been arrested. I have _______ have not _______spent time in jail, prison, or other correctional facility. If so, please explain briefly:	
Email address (I do not share your email)	
What are your current concerns or problems?	
The information included on this form is accurate, and I agree to provide updated information should changes occur. I understand my therapist requires 24 hours notice of cancellations. If 24 hours notice is not provided I will pay the full fee.	
Signature	Date