

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		Brothers				
Name	Age	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		Age	Father Living? Yes / No			
Name			Age			
Spouse's Family: Sisters		Age	Brothers			
Name			Age			
Your Children						
Name	Age	Check One				Where Residing
		His	Hers	Ours	Adopted	
1						_____
2						_____
3						_____
4						_____
5						_____

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	