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ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Patient Name _____ **Today's Date** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Please indicate if it is okay to leave a message by circling yes/no following each number listed

Home Phone _____ **yes no** **Cell Phone** _____ **yes no** **Work Phone** _____ **yes no**

E-mail Address _____

Age _____ **Date of Birth** _____ **Sex** _____ **Social Security #** _____ **Marital Status** _____

Occupation/Employer _____

Were you referred to this practice? Yes No By _____

Spouse/Partner Name _____

Address (if different from above) _____

Please indicate if it is okay to leave a message by circling yes/ no following each number listed

Home Phone _____ **yes no** **Cell Phone** _____ **yes no** **Work Phone** _____ **yes no**

Age _____ **Date of Birth** _____ **Sex** _____ **Social Security #** _____

Occupation/Employer _____

Medical Conditions and/or current medications and/or allergies _____

Have you had previous counseling? Yes No Where/When/What Reason/How Long _____

Have you ever been hospitalized for mental illness or substance abuse? Yes No If yes, for what specific reason?

Name of other persons living in your home

Relationship

Age

Emergency Contact: Name, Phone # and relationship to you _____

Please describe in your own words the current situation that led you to counseling (meaning the last two weeks): _____

Please give a brief statement about what would have to happen for you to feel like counseling was helpful to you. Describe how your life would change. _____

Please share any other information that you feel is important that is not covered above: _____

I certify that the above information is accurate.

Signature _____

Date _____