

Personal Information

Name: _____ Date: _____
Address: _____ Home #: _____
City: _____ State: _____ Zip: _____ Work #: _____
Age: _____ Birth Date: ____/____/____ Sex: _____ Marital Status: S M D W Cell #: _____
Who lives with you? _____
Education (highest grade completed)? _____ Currently a student? _____
Name of School & City: _____
Your occupation: _____ Employer Name: _____
Spouse's occupation: _____ Employer Name: _____
Parent's Name (of Minor): _____
Siblings Name & Age (of Minor): _____
Emergency Contact: _____

Name	Relationship	Phone #
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Insurance Information

Insurance Company Name (If you would like to use it): _____
Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____
Member/Certificate #: _____ Group#: _____ Insured's Name: _____
Insured's Date of Birth: _____ Relation to Insured: Self Spouse Child SS#: _____
Signature to allow my communication with your Insurance Company: _____

Mental Health Issues

Please check the areas you want to work on or feel you may need help with:

- | | | | |
|------------------|--------------------------------|----------------|-----------------|
| self-awareness | legal/police | drinking | depression |
| marital | sexual | drugs | incest |
| family/parenting | emotional | financial | self-mutilation |
| suicidality | eating/weight | anxiety/stress | relationships |
| trauma | other (please describe): _____ | | |

How long do you intend to commit to therapy? _____
Have you had previous psychological counseling? _____ Previous therapist: _____
Location of previous therapy: _____ Length: _____
Are you currently taking medication: _____ What type? _____
How did you hear about me? _____
May I say who I am if I phone your home? _____ work? _____ cell? _____