PERSONAL DATA

Date: _____ Referred By: _____

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 _____
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 _____