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## Client Information

Full Name: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

Preferred method of contact?  Email  Call my \_\_\_\_\_ phone  Text my \_\_\_\_\_ phone

Marital Status:

Single  Dating  Engaged  Married  Remarried  Separated  Divorced  Widowed  Cohabiting

If married, how long? \_\_\_\_\_ If separate/divorced, how long? \_\_\_\_\_

If married more than once, how many times? \_\_\_\_\_

### Partner Information (only if you are seeking premarital or marriage therapy)

Partner's Name: \_\_\_\_\_ Wedding Date: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

**List all children (living with you or not) and any other people living with you:**

Name	Relation	DOB	Living with you?	Parent

## Helpful Information

I attend:  Church  Synagogue  Temple  Other: \_\_\_\_\_  Not applicable

Where: \_\_\_\_\_

Please list any addictions or possible addictions: \_\_\_\_\_

\_\_\_\_\_

Have you (or your partner) ever been involved in any type of therapy?  Yes  No

If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

Reasons: \_\_\_\_\_

Why did you stop? \_\_\_\_\_

Are you (or your partner) currently seeing another counselor/psychiatrist?  Yes  No

If yes, where? \_\_\_\_\_

Have you (or your partner) ever been diagnosed with a mental illness?  Yes  No

If yes, list diagnosis: \_\_\_\_\_ Hospitalized because of it?  Yes  No

### Please check all of the following concerns that pertain to you or your family:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Finances              | <input type="checkbox"/> Insomnia          |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Drug/Alcohol Problems | <input type="checkbox"/> Religious matters |
| <input type="checkbox"/> Fears/Phobias      | <input type="checkbox"/> Career choices        | <input type="checkbox"/> Stress            |
| <input type="checkbox"/> Sexual problems    | <input type="checkbox"/> Eating disorders      | <input type="checkbox"/> Health problems   |
| <input type="checkbox"/> Suicidal thoughts  | <input type="checkbox"/> Anger                 | <input type="checkbox"/> Self-mutilation   |
| <input type="checkbox"/> Abortion           | <input type="checkbox"/> Self-control          | <input type="checkbox"/> Thought patterns  |
| <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Unhappiness           | <input type="checkbox"/> Infertility       |
| <input type="checkbox"/> Relationships      | <input type="checkbox"/> Abuse                 | <input type="checkbox"/> Marital discord   |
| <input type="checkbox"/> Parenting issues   | <input type="checkbox"/> Child discipline      | <input type="checkbox"/> Adoption          |
| <input type="checkbox"/> Other: _____       |  |  |

**I have read the Notice of Privacy Practices and Policies and Procedures. I agree to abide by the terms as indicated therein.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date