CONFIDENTIAL INFORMATION

Today's Date_____Referred by_____ Type of Counseling:□Indiv.□Couples□Fam

Name_____ Date of Birth____/____/____ Age_____

Home Address_____ City_____ Zip Code_____

Day Phone_____Ok to call? □Yes □No /Eve. Phone_____Ok to call ? □Yes □No

Email Address_____

Marital Status: Single_____ Married_____(How long?)_____Divorced_____Remarried_____

Spouse's Name (if applicable):_____Date of Birth____/____/____ Age_____

Any Children? □Yes □No If yes, please list names/ages:_____
_____
_____

What is your line of work?_____Average annual income?_____

Is spirituality/religion important to you? □Yes □NoIf yes, briefly describe_____
_____

Are you currently taking any medication? □Yes □No If yes, please list and for what purpose:_____
_____

Have you receive counseling before? □Yes □No If yes, please describe when, for what purpose and with whom:_____
_____

Who is your medical doctor?_____Phone_____Date of last physical?_____

In case of emergency, call? Name_____Phone_____Relationship_____

How would you describe your health?_____

Describe any recent changes and/or losses you have experienced over the past year:_____
_____
_____

How can counseling help you at this time?_____
_____
_____

What do you see as the problem or needed change?_____
_____
_____