

*The purpose of this form is to collect basic information about you – a bit about your background, how you found the practice, and what is bringing you to therapy at this time. Please fill it out completely so that I can learn as much as possible about you! **All information is confidential.***

Personal Information:

Today's Date: _____

Full name: _____

Address: _____

Date of Birth: ___/___/___ Age: _____

Contact Information: For each of following, please indicate whether it is okay to leave/send a detailed message by checking "yes" or "no" in the corresponding box. Mark the best way to reach you by checking "preferred"

Cell phone: _____ Yes No Preferred

Home phone: _____ Yes No Preferred

Work phone: _____ Yes No Preferred

E-mail: _____ Yes No Preferred

Referral Information: How did you hear about my practice? Knowing this helps me understand the best way to reach clients like you.

I was referred by another client. Her/his name is: _____

Is it okay for me to thank this client for referring you, without giving details about your treatment?

Yes No

I was referred by another mental health provider. Her/his name is: _____

Is it okay for me to thank this provider for referring you, without giving details about your treatment?

Yes No

I found your listing through an online therapist directory (please specify):

Psychology Today GoodTherapy.org TheKnot.com AAMFT Therapist Locator

Other (please specify): _____

Demographic Information:

Occupation: _____ Employer: _____

Average # hours worked/week: _____ I work on Weekdays Evenings Weekends

Highest level of education: High School Some college Bachelor's Degree Graduate Degree

Family Information:

Relationship Single Dating Cohabiting Married

Status: Separated Divorced Widowed Other _____

Please provide the requested information below **for each person currently living in your household** (even if they are not attending therapy with you):

Full Name	Gender	Age	Relationship to you

Please provide the requested information below for other family members who are *not* currently living in your household, but who play a significant role in your life (e.g., partner, child, parent, grandparent)

Full Name	Gender	Age	Relationship to you

Health Information: Please check “yes” or “no” for each question. If you check “yes,” please provide specific information.

Are you currently taking any prescription medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which medications and why? _____ _____
Are you currently using illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which drugs and how often? _____ _____
Are you currently drinking excessive amounts of alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many drinks do you usually have per day? _____
Are there any legal actions pending (criminal or civil)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe: _____ _____
Are you in any danger of abuse, suicide, or homicide? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe: _____ _____
Have you received therapy in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe type, duration, and reason? _____ _____
Have you ever received any psychiatric diagnoses? <input type="checkbox"/> Yes (specify): _____ <input type="checkbox"/> No	If yes, when and by whom was it given? _____
Do you have any physical health problems or concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe: _____ _____

Therapy Information:

What type of therapy are you seeking? Please select all that apply.

- Individual Couple Family Group

Please provide a brief description of the issue(s) for which you are seeking therapy, and why you are seeking therapy at this time.

Please list your initial goal(s) for therapy:

1.

2.

3.

Emergency Contacts: Please provide the name and contact information for two people you would want me to contact in the event of an emergency:

Name: _____	Name: _____
Relationship to you: _____	Relationship to you: _____
Daytime phone: _____	Daytime phone: _____
Evening phone: _____	Evening phone: _____

Is there anything else you think is important for me to know about you at this time?
