Basic Information

Full Name: ______________________________ **Date:** __________
First Middle Last

	Phone Messages OK? YES	NO	Primary contact number?
HOME: ( ) ______________	☐	☐	☐
WORK: ( ) ______________	☐	☐	☐
CELL: ( ) ______________	☐	☐	☐

Address: ______________________________

City: ______________ State: ______ Zip: __________

Gender Identification: ______________________________

Date of Birth: ______________ State of Birth: ______ Country of Birth: ______

Work (e.g., student, homemaker, volunteer, etc.):

Description:: ______________________________

Number of years: ______________________________

Current Employer: ______________________________

	Phone Messages OK? YES	NO	Primary contact number?
Phone: ( ) ______________	☐	☐	☐

Address: ______________________________

City: ______________ State: ______ Zip: __________

Title/Position: ______________________________

Number of years with current employer: ______________________________

If not currently employed:

Previous employer: ______________________________

Termination date & duration of period of unemployment: ______________________________

Family of Origin ***(Diagram or listing)*****:** ______________________________

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(If known, include dates of birth/death, yr of marriage/divorce, first names, ages.)

Significant Relationship (specify): ______________________________

Emergency Contact Information:

Name: ______________________________

	Phone Messages OK? YES	NO	Primary contact number?
HOME: ( ) ____________	☐	☐	☐
WORK: ( ) ____________	☐	☐	☐
CELL: ( ) ____________	☐	☐	☐

Address: ______________________________

City: ____________ State: ______ Zip: ____________

Your relationship to emergency contact: ______________________________

Physician Name: ______________________________

Phone: ( ) ______________________________

Address: ______________________________

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City: ____________ State: ______ Zip: ____________

Health Issue(s): ______________________________

____

____

Medications(s): ______________________________

____

Previous Therapy (*Duration of Treatment (Dates/Yrs/Your Age (Start/End*):

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Referral Source: Were you referred by an individual? (*e.g., friend/family member/Dr)*

Internet search? Website?

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