NOTE: THIS INFORMATION IS STRICTLY CONFIDENTIAL.
NO ONE IS PERMITTED TO SEE THIS FORM WITHOUT YOUR WRITTEN PERMISSION.

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Phone: ( )_____

_____ Marital Status: _____

Social Security Number: _____ Driver's License: _____

Occupation: _____ Religion: _____

Work Address: _____ Phone: ( )_____

Spouse: _____ Age: _____ Date of Birth: _____

Occupation: _____ Religion: _____

Work Address: _____ Phone: ( )_____

Years Married, Separated or Divorced: _____

Children (names, ages, sex, natural, step, etc.):

_____ _____

_____ _____

Siblings (names, ages, sex, natural, step, etc.):

_____ _____

_____ _____

Health Insurance Co: _____ Policy Number: _____

Address: _____ Phone: ( )_____

M.D.: _____ Phone: ( )_____ Last visit: _____

Last complete physical examination: _____

Health Problems: _____

Current Treatment/Medications: _____

Previous Therapist: _____ Phone: ( )_____

Dates of Therapy: _____ Reason: _____

Medical Problems in Your Family: _____

Psychological Problems in Your Family: _____

Referred by: _____

Person Through Whom You Can Always Be Reached: _____

Relationship: _____ Phone: ( )_____

Reason for Seeking Therapy: _____

Current Interests/Activities: _____

Personal/Professional Goals: _____