NEW CLIENT APPLICATION

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This application is for: ☐ Marriage and/or Couple's counseling ☐ Parent & Child

☐ Individual Female ☐ Individual Male ☐ Grief

TODAY'S DATE:__________________

NAME ___________________________________ Date of Birth _________________________

Spouse___________________________________ Date of Birth _________________________

Child_____________________________________ Date of Birth _________________________

Address____

City ____State________ Zip __________________

Home #:______________Cell #:_________________Email_____________________________

MARITAL STATUS

Single ____ / Living together for___ years / Married for _____ years / Legally Separated______

Divorced for ____ years, after ___ years of marriage / Widowed for ____ years, after ____ years of marriage

YOUR EMPLOYER____

Occupation ____________________________ Work# __________________________________

Spouse's Employer ____

EMERGENCY CONTACT: Name____

Contact #_____________________________Relationship: ______________________________

Religious Preference:____

COUNSELING HISTORY

Have you ever consulted a counselor, psychotherapist or psychiatrist before?_____Yes _____No

Name of therapist ____

Dates seen (from when to when) ____

Reason ____

MEDICAL HISTORY

Name of Primary Care Physician:________________________Contact #:__________________

Have you taken, or are you now taking, any prescription medications for mental health issues?

____Yes _____No What prescriptions? ____

____

For how long?____

Prescribed by whom and for what condition(s)?____

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Have you or other family members had a previous psychiatric hospitalization? ____Yes _____No

Who?______________________________When? _____________________________________

For what condition? ____

Please give a brief summary of the specific reason you are seeking counseling at this time. Be assured this information is confidential.

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Who referred you? ____

____

Signature *Date*

____

Signature *Date*

____

Parent/Legal Guardian Signature *Date*