



Personal Information

Name: _____ **DOB:** _____
(First) (MI) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (____) _____ **Cell Phone:** (____) _____ **Email:** _____

When necessary to you by phone, what number would you like the therapist to use? Circle all that apply.

Home Work Cell Other (if other please provide number) _____

May the therapist leave a message on your phone? Yes No

I give permission to have mail, if necessary, sent to my home. Yes No

Sex: M F **Marital Status:** Single Married Divorced Separated Widowed Living Together

Level of education: (circle one of the following) Below high school High School Some College Trade School

AA/AS Degree BA/BS Degree Graduate Degree _____ Other: _____

If a student, school of attendance _____ **Grade** _____

Occupation: _____ **How Long:** _____

Employer (or Parent's): _____

Spouse's Name: _____ **DOB:** _____

Spouse's Employer: _____

Children: _____ **DOB:** _____ **At Home?** Yes No

_____ **DOB:** _____ **At Home?** Yes No

_____ **DOB:** _____ **At Home?** Yes No

_____ **DOB:** _____ **At Home?** Yes No

Other individuals living in the home: _____

If Under 18 Years old

Father's Name: _____ **Mother's Name:** _____

Street Address: _____ **Street Address:** _____

City, State, Zip: _____ **City, State, Zip:** _____

Home Phone: _____ **Home Phone:** _____

Work Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Cell Phone:** _____

In Case of Emergency

Notify: _____

Phone: _____ **Relationship:** Wife _____

Cultural / Historical Background Information

Language(s) spoken/written fluently: _____

Ethnic Group you most closely identify with: _____

Religious Affiliation(s): _____ How often do you participate: _____

Have you seen this type of therapist previously? Yes No

If yes, what type of therapy/counseling? (Circle all that apply) Individual Couples Family Group

Dates _____ Therapist(s) _____

Are you currently under the care of another therapist? Yes No If so, whom? _____

Are you currently having any of the following problems: (if so, specify)

Legal Problems _____ Financial Problems _____

Health Information

Any illnesses, injuries, impairments/limitations, allergies? Yes No If so, explain: _____

Primary Care Physician: _____ Date Last Physical Exam: _____

Please list any prescriptions you are currently taking:

Drug: _____ Dosage: _____

Drug: _____ Dosage: _____

Drug: _____ Dosage: _____

Do you use over the counter medications? Yes No If so, what and frequency? _____

Describe the quantity and frequency of your use of the following:

Alcohol _____

Drugs _____

Caffeine _____

Nicotine/Cigarettes _____

Is there a family history of:

Alcoholism _____

Substance Abuse _____

Mental or Emotional Illness _____

Prolonged Physical Illness _____

Current Life Issues / Problems

What issues or problems have brought you to Discovery Counseling Center? _____

How were you referred to Discovery Counseling Center? _____

Signed: _____ Date: _____

(Client or Parent/Guardian of Child)