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206-427-4524

Identification Information

Date_____

Name:_____Birthdate:_____

Address:_____

City:_____State:_____Zipcode:_____

Home telephone:_____Work telephone:_____

Cellular phone:_____
*Please note if it is **NOT** okay to call or leave a message at any of these numbers.

Employer:_____Occupation:_____

Emergency Contact, Relationship, and Number:_____

_____

Referral Information

Who referred me?_____ OK to thank? Yes___No_____

Their number or address:_____

Family Information

Relationship status: ___Single ___Married ___Partnered

___Divorced ___Widow/widower

Name of partner/spouse:_____

Names of children and ages:_____

Family history of:

___Depression ___Anxiety ___Suicide ___Eating Disorders

___Violence ___Alcoholism ___Drug Abuse

___Other physical or mental illnesses_____

Medical Information

Name, phone number and address of treating physician or psychiatrist:_____

_____

Major operations/illnesses/injuries:_____

_____

Current medications Dosage Frequency Effectiveness Prescribing MD

_____

_____

Suicidality: Are you currently suicidal? _____Yes _____No

If yes, please describe_____

Have you ever attempted suicide? _____Yes _____No

If yes, please list attempts (date, method, outcome):_____

_____

Substance abuse: Do you have problems with alcohol/drugs? _____Yes _____No

Treatment Information

What brings you into counseling today? _____

_____

_____

_____

What would you like to be different in your life when you are finished with counseling?

_____

_____

_____

_____