



Personal Information

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

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

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

Home Phone: (____) _____ **His Cell Phone:** (____) _____ **Her Cell Phone:** (____) _____

His Email: _____ **Her Email:** _____

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

Home 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

Marital Status: Single Married Divorced Separated Widowed Living Together

His:

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: _____

Her:

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: _____

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: _____

In Case of Emergency

Notify: _____

Phone: _____ **Relationship:** _____

HIS 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 _____

Current Stressors _____

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 the Discovery Counseling Center? _____

Signed: _____ Date: _____

HER Cultural / Historical Background Information

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

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