Client Information

If there are any questions that you would rather not answer in writing, just leave them blank and we can discuss them in session when you are ready. All information provided is confidential.

General Information:

Client Name: _____ Date:_____

Age:_____ D.O.B.:_____ Occupation_____

Employer/School:_____

Home Address:_____

Primary Phone _____ Secondary Phone_____

May I leave a message for you at (please circle): Primary phone Secondary phone

Marital Status: Married • Remarried • Single • Single Parent • Widow(er)
Divorced • Separated • Partnered

If Applicable, Spouse's Name:_____

Do you have any children? Yes • No

If yes, Names and Ages:_____

_____

Who lives in your home?_____

Permanent Address (same as above____) _____

_____

Emergency Contact name and phone #:_____

_____

May I contact you via email or via text messaging to discuss scheduling and other related issues? Email: Yes No Text Messaging: Yes No

E-Mail: _____

How did you hear about Roxanne Strauss, LMFT?

If applicable, may I thank your referral source? Yes • No

Areas of Concern:

What issues or concerns bring you to therapy today?

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What are your goals for therapy? What do you hope to receive from therapy?

Do you have any concerns regarding therapy?

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)?

Yes • No If yes, when and for how long?

Please briefly describe the reasons:

Medical Information:

Are you currently taking any medications? Yes • No

Please list all medications:_____

_____

_____

_____

If you are taking prescription medications, who is the prescribing physician? How long have you been taking the medications?

Have you ever been diagnosed with a serious illness? If yes, please describe.

At any time in your life, have you experienced any bodily injuries needing medical treatment (for example, head injury or concussion, broken bones, etc)? If yes, please explain.

How would you describe your overall health?_____

Do you smoke tobacco cigarettes, vapor cigarettes, or cigars? Yes No
If yes, how much? _____ For how long? _____

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Do you smoke/use marijuana? Yes No
If yes, how often do you smoke/use marijuana in a week? _____
Do you drink alcohol? Yes No
On average, how much alcohol do you consume in a week? _____
Do you take illegal drugs? Yes No

Family of Origin History

Please briefly describe your childhood.

Are your parents living or deceased? Mother _____ Father _____
Do you have stepparents? (please circle) Stepmother Stepfather
If applicable, are your stepparents living or deceased? Stepmother _____ Stepfather _____

Names and ages of siblings:

Other Information

Please describe your spiritual identity/orientation.

Do you wish to incorporate your spiritual identity into your therapy? Yes No

Please describe your interests/hobbies.

Are you now or have you ever been involved in a lawsuit? Please briefly describe.

Is there anything else you would like me to know that you believe may be relevant to your therapy?

Signature: _____

Printed Name: _____