

Confidential: Request for Service

Section 1: Personal Information

Name: _____ Date: _____

Mailing Address: _____ D.O.B. ____ / ____ / ____ Sex: M F

_____ Sexual Orientation: _____

City State Zip

E-mail: _____

Phone: (Day) _____ (Evening) _____ (Cell) _____

Please List Your Preferred Contact Number: _____

Emergency Contact Person: _____

Relationship: _____ Phone: _____

Section 2: Health History & Other Information

Relationship Status: 1) ___ Single 2) ___ Married 3) ___ Separated

4) ___ Divorced 5) ___ Committed Relationship

Have you had previous counseling? _____ If Yes, please check all that apply:

With Whom? When? For How Long?

1) ___ Private Therapist _____

2) ___ Community Agency _____

3) ___ Hospital _____

4) ___ Counseling Center _____

5) ___ Other (Please Specify) _____

Do you have any health concerns? _____ If Yes, please describe: _____

Are you currently taking any medications? _____ If Yes, please specify medication(s) and your prescribing physician: _____

What concerns bring you to counseling? _____

When did these problems begin? _____

What have you been doing to cope with these problems? How successful have your efforts been? _____

What do you hope to accomplish in counseling? _____

Please fill out the following information about your family history. List all members of your immediate family including parents, siblings, spouse/partner, and children. Please identify their relationship to you, their age and occupation as well as whether they are living or deceased.

Relationship To You	Age	Occupation	Living?
1. _____			Y N
2. _____			Y N
3. _____			Y N
4. _____			Y N
5. _____			Y N
6. _____			Y N
7. _____			Y N
8. _____			Y N
9. _____			Y N

Please use the extra space provided below if you need more space.

Are your parents separated or divorced? _____ If yes, please list the year of divorce or separation: _____

How did you hear about my services? _____

Please use the space below for anything else you would like to add: _____
