HEALING AND RECOVERY

Adult Personal Information

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Email _____ OK to contact? Yes/No

Phone _____ (home/cell) OK to contact? Yes/No

Date of Birth _____/_____/_____ Age _____ Gender _____

Marital Status: Single/Married/Separated/Divorced/Widowed/Cohabitating

If married, separated, divorced, widowed, or cohabitating, how long? _____

Name of spouse/partner _____ Date of Birth _____/_____/_____

Have Children? Yes/No If yes, how many?_____

Names and Ages of Children?

_____ _____

_____ _____

_____ _____

Any Health Issues? Yes/No

If yes, please specify, including any prescription medications you are currently using: _____

_____

Have you ever seen a therapist before? Yes/No

If yes, when and why? _____

_____

Have you ever attempted suicide? Yes/No

If yes, when? _____

Briefly describe your reason for coming to counseling today: _____

_____

Fears or concerns about counseling: _____

_____

Goals or expectation of counseling: _____

_____

How did you hear about us? _____

In Case of Emergency:

I authorize you to contact _____ Relationship _____

Phone Number _____ Alternate Phone Number _____