Date:_____

Name: _____ Date of Birth: _____

Home address: _____

Phone number: _____ Can I leave a message at this number? Yes / No

Please share the names and roles of other family members at home or close by (e.g. parents/children):

_____

_____

Marital Status: _____ If not married, are you in a dating relationship?:_____

Are you connected with a religious or spiritual community? If so, please share: _____

How significant is this religious/spiritual community for you? 1 2 3 4 5
Low High

Please share **your** reason for seeking counseling at this time:

_____

_____

What outcomes do **you** hope to gain from counseling?

_____

_____

Please list any significant health related difficulties for you either current or in the past (physical or mental/emotional):

_____

_____

Do you take any medications? If so, please list the type and dosage:

_____

_____

Have you ever received counseling or therapy before (either individual or as a couple)?: Yes / No

If so, please describe the type and quality of your experience: _____

_____