

Client Information

Client Name	Age
SSN	Date of Birth / /
Street Address	City State Zip
Email address	
Home phone ()	Work () Cell ()
Can we contact you at home? Yes _____ No _____	Can we contact you at work? Yes _____ No _____

Occupation	Current Position
Employed by:	How long?
Work Address	City State Zip

Name of person financially responsible	Age
SSN	
Street Address	City State Zip
Home phone ()	Work phone ()
Client's relationship to responsible party:	

Briefly describe your reasons for seeking help

Referral Information

Name

Contact phone number ()

Client's relationship to referral

May we contact your referral source?

Yes _____ No _____

Marital Status (check one)

Single _____ Married _____ Divorced _____ Widowed _____ Life Partner _____

Other _____

Is this your first marriage? Yes _____ 2nd _____ 3rd _____ 4th _____ 5th _____

How old were you when you married? 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Duration of each marriage 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Current spouse's name

Current Partner's name

Spouse's Occupation

Employed by

List all people currently living in your home

Name	Age	Relationship	School/Occupation

Describe any major changes in your life in the past two years

Have you ever seen a psychotherapist or counselor of any type before? Yes _____ No _____
If yes, what were the dates, reasons, and the results of your previous therapy?

Physician Name	Phone ()
Address	City State Zip
Date of last physical examination	
Results	
List any health problems	
Describe your average daily intake of:	
Prescription Drugs (list names & dosage) _____	
Tobacco products _____	
Caffeine _____	
Alcohol _____	
Other Drugs _____	

Please circle all of the following areas in which you are having difficulty:

nervousness	depression	fears	anxiety
shyness	sexual problems	suicidal thoughts	panic attacks
divorce	boredom	finances	heart palpitations
drug use	alcohol use	friends	edgy
anger	self-control	unhappiness	intimacy
insomnia	stress	work	phobias
relaxation	headaches	dating skills	moodiness
legal matters	memory	assertiveness	having fun
low energy	isolation	making decisions	making friends

loneliness	self-esteem	concentration	inferiority
education	career choices	health problems	keeping a job
relationships	nightmares	marriage	irritability
children	eating problems	perfectionism	mood changes
bowel troubles	being a parent	my thoughts	family
Other: _____			

Other information that you think would be useful:

Name of person to be contacted in case of emergency			
Relationship			
Street Address	City	State	Zip
Home phone ()		Work phone ()	

I authorize Sue Passalacqua, M.S., MFT #46069 to release any medical information regarding the medical, mental health, or alcohol/drug abuse history, treatment, or benefits payable, including disability or employment related information to any insurance company, the Plan Administrator, or their authorized agents that I may have coverage with, for the purpose of validating and determining benefits payable for my treatment. In signing this statement, I am aware that confidentiality regarding information given to managed care/insurance companies is relinquished. My confidentiality in this regard is protected only by the laws and ethics governing the managed care and insurance companies.

Date

Client signature (parent if client is a minor)