



turnerwood

MARRIAGE AND FAMILY THERAPY, INC.

CLIENT INFORMATION SHEET (ADULTS AND COUPLES)

Name: _____
Address: _____
City: _____ Zip: _____
Date of birth: _____ Age: _____
Occupation: _____

Name: _____
Address: _____
City: _____ Zip: _____
Date of birth: _____ Age: _____
Occupation: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

EMERGENCY CONTACT

Name: _____
Address: _____ City: _____ Zip: _____
Phone number: _____ Relationship to you: _____

MARITAL STATUS

Single Married Separated Widowed Cohabiting Remarried Divorced

CHILDREN AND STEP-CHILDREN

Name: _____ Age: _____ Child Step-child
Name: _____ Age: _____ Child Step-child
Name: _____ Age: _____ Child Step-child
Name: _____ Age: _____ Child Step-child
Name: _____ Age: _____ Child Step-child
Name: _____ Age: _____ Child Step-child

MEDICATION

Name/dosage: _____ Prescribed for: _____ Doctor: _____
Name/dosage: _____ Prescribed for: _____ Doctor: _____
Name/dosage: _____ Prescribed for: _____ Doctor: _____

HOW DID YOU HEAR ABOUT US?

Google Search Friend/Family referral Psychology Today Listing Good Therapy Listing
 Other (describe): _____



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CURRENT GOALS AND CONCERNS (YOUR REASONS FOR COMING TO COUNSELING):

1. _____
2. _____
3. _____
4. _____

INDICATE EACH OF THE STRESSORS YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS:

- | | | |
|--|---|---|
| <input type="checkbox"/> Loss of job | <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Increase in number of arguments |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Panic or anxiety attacks | <input type="checkbox"/> Outstanding personal achievement |
| <input type="checkbox"/> Stopped smoking | <input type="checkbox"/> Death of a close friend | <input type="checkbox"/> Anger management problems |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Death of close family member | <input type="checkbox"/> Other self-control problems |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Alcohol or drug problems |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Arrest or pending charges | <input type="checkbox"/> Significant weight loss/ gain |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Incarceration/ conviction | <input type="checkbox"/> Significant changes in memory or attention |
| <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Major accident/injury/ illness | |
| <input type="checkbox"/> New family member | <input type="checkbox"/> Involved in lawsuit | |

HAVE YOU RECENTLY EXPERIENCED ANY CHANGES IN:

- | | | |
|--|--|--|
| <input type="checkbox"/> Empty nest | <input type="checkbox"/> Living arrangements (moved) | <input type="checkbox"/> Sleeping habits |
| <input type="checkbox"/> Eating habits | <input type="checkbox"/> Family responsibilities | <input type="checkbox"/> Exercise habits |
| <input type="checkbox"/> Social activities | <input type="checkbox"/> Work responsibilities | <input type="checkbox"/> Other: _____ |

PREVIOUS COUNSELING OR THERAPY:

- | | | | |
|-------------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Group | <input type="checkbox"/> Psychologist | <input type="checkbox"/> LPCC |
| <input type="checkbox"/> Couple | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> LCSW |
| <input type="checkbox"/> Family | <input type="checkbox"/> Inpatient | <input type="checkbox"/> MFT | <input type="checkbox"/> Other: _____ |

Name of provider: _____ How long? _____

Reason for treatment: _____ Results: _____

I have answered these questions to the best of my knowledge.

Signature: _____ Date: _____

Signature: _____ Date: _____