

Date: _____

Name: _____ Date of Birth: _____ Age: _____ SS#: _____ - _____ - _____

Address: _____ Home #: (_____) - _____

City: _____ St.: _____ Zip: _____ Cell #: (_____) - _____ Wk#: (_____) - _____

Highest Level of Education: _____ Occupation: _____

Marital Status: Single Married Separated Divorced Widowed Living together as a couple

Name of Legal Guardian (if client is under 18): _____ Legal Guardian's Relationship to Client: _____

Name of Emergency Contact: _____ Emergency Contact Phone #: (_____) - _____

How did you hear about Lanier Counseling Services? _____

Have you had any prior counseling, psychological or psychiatric treatment? Yes No

If Yes When? _____ With Whom? _____

Who is your Primary Care Physician (PCP)? _____

PCP Phone #: (_____) - _____

Are you currently taking any medications? Yes No

If "Yes", please list all medications relevant to therapy:

Date of last physical exam: _____

Do you have any medical conditions relevant to therapy? Yes No

If "Yes" Please list them: _____

What is the primary reason you are seeking counseling? _____

How long has this problem persisted? _____

What would you like to get out of counseling? _____

I am currently experiencing:	I have a history of:	Problem Categories "X" all that apply - circle primary
_____	_____	1. Alcohol
_____	_____	2. Drugs (specify)
_____	_____	3. Emotional Problems
_____	_____	4. Marital Problems
_____	_____	5. Family
_____	_____	6. Physical Health (specify)
_____	_____	7. Another's alcohol or drug
_____	_____	8. Another's emotional health
_____	_____	9. Legal/Financial Problems
_____	_____	10. Other (specify)

Level of severity (How much do these problems bother you?)
 Minimal Mild Moderate Severe Extreme