



BASIC INFORMATION

Date: _____

Name: _____

Age: _____

Best way to contact you: Home Phone: _____ Cell Phone: _____

E-mail _____

Restrictions on calling or email? _____

Employment/Type of _____

Education: _____

Name of Significant Other: _____

Names and Ages of Children: _____

Emergency Contact: _____

Phone: _____

Referral Source: _____

Previous Counseling or Psychiatric Experience: When? _____ With whom? _____

Describe briefly _____

Current Medications: _____

Are you currently experiencing feelings of wanting to hurt yourself? _____ Someone else? _____

Please describe _____

Previous or past diagnoses: _____

Presenting Problem: _____

Notes: _____