Margaret Grundstein | M.F.T.

CLIENT INFORMATION FORM

NAME _____ DATE _____

FAMILY COMPOSITION (List you and other family members who may be involved in treatment)

Name Age Birth Place Occupation or Current School

_____

_____

_____

ADDRESS _____

CITY/ZIP _____

HOME PHONE # _____ BUSINESS # _____ CELL# _____

May I contact you by mail? YES____NO____By e-mail? YES____NO____ By text? YES____NO____

DRIVER'S LIC# _____E-MAIL ADDRESS_____

MARITAL STATUS _____ CHILDREN/AGES _____

_____

WITH WHOM DO YOU LIVE? SPOUSE _____ PARENTS _____ OTHER _____

PLEASE LIST ANY CURRENT HEALTH PROBLEMS _____

_____

PLEASE LIST ANY MEDICATIONS AND DOSAGES _____

_____

PHYSICIAN'S NAME/ PHONE # _____

HAVE YOU BEEN HOSPITALIZED FOR PSYCHOLOGICAL REASONS OR DRUG DEPENDENCY?

YES_____NO_____If yes, please describe_____

NAME/NUMBER OF PSYCHIATRIST (If Applicable)_____

ISSUES THAT BRING YOU TO THERAPY _____

_____

PRIOR THERAPIST (S) AND LENGTH OF THERAPY _____

_____

REFERRED BY _____ PERMISSION TO ACKNOWLEDGE? _____

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