

The Offices of Life in Progress, Inc.  
Annette R. Smith, MA, LMFT, LPCC

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City & Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Client's Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Ethnicity \_\_\_\_\_  
Social Security No. \_\_\_\_\_  
Occupation \_\_\_\_\_ Employed Yes/No How Long \_\_\_\_\_  
Monthly Household Income \$ \_\_\_\_\_ # in Household \_\_\_\_\_  
Currently in School Y/N (Full/Part Time) Highest Completed Grade \_\_\_\_\_

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Relationship Status S/M/D/W \_\_\_\_\_ How Long \_\_\_\_\_  
Spouse's name (if applicable) \_\_\_\_\_  
Number of Pregnancies \_\_\_\_\_ Number of Children \_\_\_\_\_  
Children's Ages, Gender and Names:

\_\_\_\_\_  
\_\_\_\_\_

Do all the children reside with you? If not, where do they live and how often do you see them: \_\_\_\_\_  
\_\_\_\_\_

Check the problem areas that are leading you to seek counseling:

Marital	___	Emotional	___	Alcoholism or Drinking Problem	___		
Family	___	Financial	___	Personal Relationships	___		
Legal	___	Employment	___	Parental Issues	___		
Sexual	___	Drub Abuse	___	Major Stressor	___	Other	___

Please write a brief statement of your current problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Family History - Indicate if any of the following is true for yourself or a family member

	<u>Self</u>	<u>Mother</u>	<u>Father</u>	<u>Sibling</u>	<u>Grandparent</u>
Depression	___	___	___	___	___
Suicide	___	___	___	___	___
Suicide Attempt (#)	___	___	___	___	___
Alcohol Problem	___	___	___	___	___
Drug Problem	___	___	___	___	___
Mental/Emotional Problem	___	___	___	___	___
Abuse	___	___	___	___	___

Medical History - Circle all of the following which you have now or had in the past

Heart Trouble	Frequent/Severe Headaches	Head Injury
Diabetes	High Blood Pressure	Fainting/Dizziness
Stroke	Shortness of Breath	Stomach Problems
Kidney Trouble	Bedwetting/Soiling	Epilepsy/Convulsions
Back Problems	Unusual Bleeding	Asthma/Hay Fever
Arthritis	Sleep Difficulty	Mood Changes
Cancer	Thyroid Trouble	Neurological Disease

Any other serious illness(es) or surgery: \_\_\_\_\_

Name, address & telephone # of physician: \_\_\_\_\_

Date of Last Exam \_\_\_\_\_ General Health \_\_\_\_\_

List all medications you are now taking (including prescription and non-prescription):

<u>Medication/Strength</u>	<u>Dosage per Day</u>	<u>Prescribed By</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Psychotherapy - Have you consulted a therapist of any type in the past Yes/No

<u>Name</u>	<u>Address</u>	<u>Dates of Service</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for psychiatric reasons in the past? Yes/No

<u>Hospital</u>	<u>Address</u>	<u>Dates of Hospitalization</u>
_____	_____	_____
_____	_____	_____

\_\_\_\_\_

Please provide people we can contact in case of an emergency

Name

Phone Number

Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Appointment Cancellations

If an appointment is cancelled or missed **without 24 hours prior notice**, a regular charge will be made. Monday appointments must be cancelled by noon on the preceding Friday.

Whom may we thank for referring you to us? \_\_\_\_\_

This form was completed by \_\_\_\_\_ on \_\_\_\_\_

Name

Date