D A V I D  M I C H A L I C E K,  M. A.
Licensed Marriage and Family Therapist

# CLIENT INFORMATION

Name (printed): _____ Birth date: _____ Gender: M / F

Marital Status (please check): ☐ Single ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail _____

Occupation _____ Employer _____ How Long _____

Referral Source (circle): General Internet Search Google Ad Psychology Today Listing

Personal Referral:_____ Ok for me to say thank you: Yes No

## EMERGENCY CONTACT

Name _____ Relationship: _____ Phone: _____

## TREATMENT HISTORY

List any major current physical or mental health problems:_____

_____

Have you been in therapy before? _____ If yes, when? _____ Problem?_____

Whom did you see?_____ Did it help? _____

Have you ever been hospitalized? Yes____ No ____

If yes, for what condition(s):_____

Are you currently under treatment for a medical condition? Yes ____ No ____

Please list any substances you use and/or medications you are taking (use back if necessary):

_____

_____

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Please list information about anyone currently living with you:

NAME AGE RELATIONSHIP (e.g. son, roommate)

Are you having any suicidal thoughts or plans at this time? Yes No

Have you had suicidal thoughts in the past? Yes No

Are you having any thoughts of committing violence towards others or property? Yes No

Do you have access to weapons? Yes No

What was the catalyst or reasons for your seeking therapy now?:

What outcomes do you hope to get out of therapy?

Signature: _____ Date: _____

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P H O N E : ( 4 0 8 ) 6 2 8 – 9 1 7 9