Life Therapy
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Client Information

Client Name			Age
SSN		Date of Birth	/ /
Street Address	City	State	Zip
Email address			
Home phone ( )	Work ( )		Cell ( )
Can we contact you at home? Yes ◉ No ○		Can we contact you at work? Yes ◉ No ○	

Occupation		Current Position	
Employed by:		How long?	
Work Address	City	State	Zip

Name of person financially responsible			Age
SSN Date of Birth			
Street Address	City	State	Zip
Home phone ( )		Work phone ( )	
Client's relationship to responsible party:			

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Briefly describe your reasons for seeking help

Referral Information Name	Contact phone number ( )
Client's relationship to referral	May we contact your referral source? Yes ◉ No ○

Marital Status (check one)

Single ○ Married ◉ Divorced ○ Widowed ○ Life Partner ○
Other ○

Is this your first marriage? Yes ○ 2nd ◉ 3rd ○ 4th ○ 5th ○

How old were you when you married? 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____

Duration of each marriage 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____

Current spouse's name
Current Partner's name

Spouse's Occupation Employed by

List all people currently living in your home Name	Age	Relationship	School/Occupation

Describe any major changes in your life in the past two years

Have you ever seen a psychotherapist or counselor of any type before? Yes ⊙ No ◯
If yes, what were the dates, reasons, and the results of your previous therapy?

Physician Name Phone ( )
Address City State Zip
Date of last physical examination
Results
List any health problems
Describe your average daily intake of:
Prescription Drugs (list names & dosage) _____
_____
Tobacco products _____
Caffeine _____
Alcohol _____
Other Drugs _____

Please check the following areas which you are having difficulty

nervousness	depression	fears	anxiety
shyness	sexual problems	suicidal thoughts	panic attacks
divorce	boredom	finances	heart palpitations
drug use	alcohol use	friends	edgy
anger	self-control	unhappiness	intimacy
insomnia	stress	work	phobias
relaxation	headaches	dating skills	moodiness
legal matters	memory	assertiveness	having fun
low energy	isolation	making decisions	making friends

loneliness	self-esteem	concentration	inferiority
education	career choices	health problems	keeping a job
relationships	nightmares	marriage	irritability
children	eating problems	perfectionism	mood changes
bowel troubles	being a parent	my thoughts	family
	Other:_____		

Other information that you think would be useful:

Name of person to be contacted in case of emergency Relationship			
Street Address	City	State	Zip
Home phone ( )		Work phone ( )	

I authorize Sue Passalacqua, M.S., MFT #46069 to release any medical information regarding the medical, mental health, or alcohol/drug abuse history, treatment, or benefits payable, including disability or employment related information to any insurance company, the Plan Administrator, or their authorized agents that I may have coverage with, for the purpose of validating and determining benefits payable for my treatment. In signing this statement, I am aware that confidentiality regarding information given to managed care/insurance companies is relinquished. My confidentiality in this regard is protected only by the laws and ethics governing the managed care and insurance companies.

_____ _____

Date Client signature (parent if client is a minor)