Shannon Lee L.M.F.T.

Licensed Marriage and Family Therapist MFT#47482

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Although some questions here may seem unnecessary, they will help me to better understand you and your situation. **Please fill in all information or fill in: N/A to ensure each question is addressed with no blank areas**. Social Security number is required if you will be paying with insurance.

Today's Date: _____ email: _____

Client Name (child):_____SS#:_____

Client (child) DOB: _____

1. Parent Name _____

Street Address:_____

City: _____Zip Code: _____

Home Phone:_____CellPhone:_____WkPhone:_____

Parent Date of Birth:_____Age:_____Marital Status: _____

2. Parent Name _____

Street Address:_____

City: _____Zip Code: _____

Home Phone:_____CellPhone:_____WkPhone:_____

Parent Date of Birth:_____Age:_____Marital Status: _____

PERSON AND TEL. NO. TO CALL IN EMERGENCY: _____

Child MEDICAL DOCTOR(S): _____ PHONE(S): _____

LAST MEDICAL EXAM: _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations): _____

_____

_____

_____

Any current medical problems?

_____

_____

List any current medications with name/dosage and length of time prescribed and why prescribed:

_____

_____

_____

_____

PRESENTING PROBLEM/symptoms: _____

_____

_____

_____

_____

CURRENT Medical Health Rated: _____ Excellent _____ Good _____ Fair _____ Poor

PAST/PRESENT COUNSELING/PSYCHOTHERAPY:

1.Therapist: _____Dates: _____ to _____ Phone: _____
Address: _____
Initial reason: _____ Process and outcome: _____
2. Therapist: _____Dates: _____ to _____ Phone: _____
3. Address: _____
Initial reason: _____ Process and outcome: _____

Previous Mental Health Diagnosis: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):

_____

_____

FOR CHILD CLIENTS:

School:_____

Grade:_____ Teacher:_____Special Education? Yes____No____

PARENT WORK INFORMATION:

Employer:_____ How long at this job? _____

INSURANCE:

Carrier:_____ ID#:_____

Group #: _____ Phone #: _____

Primary Insured's Name/SS#/Date of Birth:_____

_____

FAMILY MEMBERS IN HOME:

Name:	Age:	Relationship:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

6. _____ _____ _____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

_____

_____

Why are you seeking treatment at this time?

_____

_____

_____

What would you like to accomplish or work toward in treatment?

_____

_____

_____

How were you referred to me? _____

Will you give permission for this office to send the referral source a thank you note?

Yes ____ No ____