

TAMAR COUNSELING SERVICES

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909-547-HURT (4878)

NAME _____ AGE _____ DATE OF BIRTH _____
ADDRESS _____ CITY/ZIP _____
SOC.SEC.# _____ DRIVER'S LIC.# _____
PRIMARY LANGUAGE _____ ETHNICITY _____
HOME PHONE _____ CELL PHONE _____ EMAIL: _____
NAME OF EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____ CITY/ZIP _____
EDUCATION / DEGREE(S) _____
MARITAL STATUS _____ NAME & AGE OF CHILDREN _____
RELIGIOUS BACKGROUND / TRADITION _____
CURRENT LIVING SITUATION _____
DESCRIBE ANY HEALTH PROBLEMS _____
MEDICATIONS YOU TAKE & DOSAGE _____
DOCTOR'S NAME AND PHONE NUMBER _____ (_____) _____
PSYCHIATRIST'S NAME AND PHONE NUMBER (if applicable): _____

IN YOUR FAMILY, INCLUDING YOURSELF, WAS / IS THERE:

ALCOHOLISM? YES/NO FATHER / MOTHER / SIBLINGS / SELF HOW LONG? _____

RESOLVED?: _____

SUBSTANCE ABUSE? YES/NO FATHER / MOTHER / SIBLINGS / SELF HOW LONG? _____

RESOLVED?: _____

MENTAL ILLNESS? YES/NO FATHER / MOTHER / SIBLINGS / SELF HOW LONG? _____

DIAGNOSIS: _____

RESOLVED?: _____

SERIOUS ILLNESS? YES/NO FATHER / MOTHER / SIBLINGS / SELF HOW LONG? _____

DIAGNOSIS: _____

RESOLVED?: _____

CRIMINAL RECORD / LEGAL PROBLEMS? YES/NO FATHER / MOTHER / SIBLINGS / SELF

CHARGES: _____ RESOLVED? _____

YOUR PAST MENTAL HEALTH TREATMENT:

AGENCY / CLINICIAN NAME: _____ DATES: _____

PHONE NUMBER:(_____) _____ REASON FOR TREATMENT: _____

AGENCY / CLINICIAN NAME: _____ DATES: _____

PHONE NUMBER:(_____) _____ REASON FOR TREATMENT: _____

WHAT ARE YOU HOPING TO GAIN FROM OR CHANGE IN THERAPY? (feel free to use other side): _____

EMERGENCY CONTACT NAME/RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBERS: (_____) _____

IF THE CLIENT IS A MINOR, WHO IS THE LEGAL GUARDIAN? _____

HOW DID YOU HEAR ABOUT MY SERVICES? _____

PLEASE SIGN BELOW TO INDICATE THAT THE INFORMATION PROVIDED IS TRUE & CORRECT:

SIGNATURE: _____ DATE: _____