TAMAR COUNSELING SERVICES

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NAME ___________________________ AGE ____________ DATE OF BIRTH____________________
ADDRESS ____ CITY/ZIP __________________________
SOC.SEC.#_______________________________________ DRIVER'S LIC.# ____________________
PRIMARY LANGUAGE ______________________________ ETHNICITY ________________________
HOME PHONE ______________ CELL PHONE______________EMAIL:_________________________
NAME OF EMPLOYER / SCHOOL___________________________ OCCUPATION ________________
BUSINESS ADDRESS ______________________________ CITY/ZIP_____________________________
EDUCATION / DEGREE(S)____
MARITAL STATUS__________ NAME & AGE OF CHILDREN ________________________________
RELIGIOUS BACKGROUND / TRADITION & CHURCH (IF APPLICABLE)_________________________
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?_________________________
PHYSICAL / SEXUAL / EMOTIONAL ABUSE? YES/NO VICTIM (SELF / OTHER):__________________
PERPETRATOR:______________________________________ CHARGES / INTERVENTION? YES/NO

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:________________