Shelby Riley, LMFT and Associates, LLC

Marriage and Family Specialists

223 Byers Road, Suite 7
Chester Springs, PA, 19425

CONFIDENTIAL CLIENT INFORMATION

Adult Information

NAME_____ DOB_____

STREET ADDRESS_____CITY _____ZIP_____

TELEPHONE (h)_____(wk)_____(cell)_____

EMAIL_____

OCCUPATION_____EMPLOYER NAME_____

HIGHEST GRADE/DEGREE_____REFERRED BY_____

MAY WE THANK THEM FOR THE REFERRAL? YES NO

RELIGIOUS AFFILIATION (if any)_____

MARITAL STATUS_____PREVIOUS MARRIAGE(s)_____

CHILDREN/STEP/GRAND (names, ages)_____

EMERGENCY CONTACT NAME_____PHONE #_____

Second Client /Spouse/Partner Information

NAME_____ DOB_____

STREET ADDRESS_____CITY_____ZIP_____

TELEPHONE (h)_____(wk)_____(cell)_____

OCCUPATION_____EMPLOYER NAME_____

EMAIL_____

HIGHEST GRADE/DEGREE_____ RELIGIOUSAFFILIATION (if any)_____

MARITAL STATUS_____PREVIOUS MARRIAGE(s)_____

CHILDREN/STEP/GRAND (names, ages)_____

EMERGENCY CONTACT NAME_____PHONE #_____

Minor Client

CHILD(REN)'S NAME(S) and DOB:_____

STREET ADDRESS_____CITY_____ZIP_____

TELEPHONE (h)_____(cell)_____

PARENTS' MARITAL STATUS_____

CUSTODY ARRANGEMENT _____

PERSON RESPONSIBLE FOR ACCOUNT _____

Treatment Information

CURRENT REASONS FOR SEEKING COUNSELING:

_____
_____
_____

* Please specify whose information - if more than one client.
MEDICAL DOCTOR(s)_____PHONE #_____

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

_____
_____

CURRENT MEDICATIONS (include dosage):_____

PAST/PRESENT COUNSELING:
1. Therapist: _____Phone #_____

Initial reason for treatment _____Length of treatment _____

2. Therapist _____Phone #_____

Initial reason for treatment _____Length of treatment _____

LIST ANY CURRENT PHYSICAL SYMPTOMS (such as appetite loss, overeating, low energy, insomnia, headaches, dizzy spells, numbness, epilepsy, chronic pain, anxiety, sweating, shakes, etc):

_____
_____

LIST ANY CURRENT EMOTIONAL SYMPTOMS (such as depression, crying spells, anxiety, fear, grief, hearing voices, angry outbursts, suicidal thoughts, nightmares, etc.):

_____
_____

PAST/PRESENT DRUG OR ALCHOHOL USE/ABUSE (includes duration of use, sobriety or recovery, any involvement in AA/NA, etc.):

_____
_____

FAMILY HISTORY OF ALCHOLISM, MENTAL ILLNESS, VIOLENCE OR SUICIDE:

_____
_____
_____

PERTINENT DEVELOPMENTAL HISTORY:

_____
_____
_____

Use space below to give further information.

_____
_____
_____