Shelby Riley, LMFT and Associates, LLC

Marriage and Family Specialists

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

CONFIDENTIAL CLIENT INFORMATION

First Adult Information

NAME_____ DOB_____

STREET ADDRESS_____CITY _____ZIP_____

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

EMAIL_____

OCCUPATION_____

REFERRED BY_____

MAY WE THANK THEM FOR THE REFERRAL? YES ◉ NO ◯

RELIGIOUS AFFILIATION (if any)_____

RELATIONSHIP STATUS_____

CHILDREN (names, ages)_____

EMERGENCY CONTACT NAME_____PHONE #_____

Second Adult Information

NAME_____ DOB_____

STREET ADDRESS_____CITY _____ZIP_____

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

EMAIL_____

OCCUPATION_____

RELIGIOUS AFFILIATION (if any)_____

RELATIONSHIP STATUS_____

CHILDREN (names, ages)_____

EMERGENCY CONTACT NAME_____PHONE #_____

Minor Client

CHILD(REN)'S NAME(S)_____DOB(s)_____

STREET ADDRESS_____CITY_____ZIP_____

TELEPHONE (h)_____(cell)_____

PARENTS' RELATIONSHIP STATUS_____

CUSTODY ARRANGEMENT _____

PERSON RESPONSIBLE FOR ACCOUNT _____

Client Name_____

Treatment Information

CURRENT REASONS FOR SEEKING THERAPY:

* 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 ALCOHOL USE/ABUSE (includes duration of use, sobriety or recovery, any involvement in AA/NA, etc.):

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

ANY ADDITIONAL INFORMATION YOU'D LIKE TO SHARE: