

G. Pat Stogner, M.Ed.
Licensed Marriage and Family Therapist

PERSONAL INFORMATION

Name: _____ Date: _____
Social Security Number: _____ Age: _____ DOB: _____
Home Address: (street) _____
(city) _____ (state) _____ (zip) _____
(May we contact you by mail? yes no)

List any numbers by which we may contact you. If couples therapy, list for both people.
Home phone: _____
Work phone: _____
Cell phone: _____
Email: _____

Household Members:
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

If you are using a health insurance plan or EAP, please complete the information below:
Insurance Company or EAP: _____
Phone number: _____
Your co-pay amount: _____ Deductible: _____
Claims address:
(street) _____
(city) _____ (state) _____ (zip) _____

List any medications you are presently taking.

Medication:	M.D. prescribing:	Why prescribed?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Counseling:	Why seen?	Helpful?
Dates seen: _____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no