

Date: _____

CLIENT INFORMATION

Name		Best Phone Number	Alternate Phone Number	Date of Birth
Street Address		<input type="checkbox"/> Own <input type="checkbox"/> Rent	In case of emergency notify (name, relationship and phone number):	
City	State		Zip	
		<input type="checkbox"/> Never Married <input type="checkbox"/> Living as Married <input type="checkbox"/> First Marriage <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Place of Birth	
Email:		Place of Employment		Education
Would you like to be included on the mailing list for occasional newsletters or presentations by Brian? Y / N (Confidential mailing list is not shared with anyone.)		Type of Work		Annual Household Income
If you surfed the Internet to contact Brian, which website? <input type="checkbox"/> NWTherapyNetwork.com <input type="checkbox"/> AMHA <input type="checkbox"/> Google <input type="checkbox"/> GoodTherapy.org <input type="checkbox"/> Psychology Today <input type="checkbox"/> bhfarr.com		Who told you about Brian Farr? May I thank them? Y / N		
Briefly describe the benefits you want from our counseling sessions: _____ _____				
Your Family / Current Household Members (Spouse/Partner, Children, Step-Children):				
Name	Age	Relationship	Grade/Occupation	Living at home?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Your Family of Origin (Mother, Father, Brothers, Sisters, Step-Siblings):				
Name	Age	Relationship	Occupation	Living within 50 miles?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Who took care of you during the first five years of your life?		Age when you left home? Reasons for leaving?		
What was your childhood religion and/or sense of spirituality?		Military Service? Approximate Dates? Combat Duty?		
Current physical problems or complaints?		How much do you consume in an average day? Caffeine: Alcohol: Tobacco:		
Current prescription medications?		Have you seen another psychotherapist in the past two years? Name(s)?		

Please check your current concerns and underline your historical issues. When was your most recent physical exam? _____

Fatigue
 Grief/Loss
 Feelings of Hopelessness
 Crying Spells
 Depression
 Thoughts of Hurting Yourself
 Suicidal Thoughts
 Anxiety
 Excessive Energy
 Anger
 Feeling Out of Control
 Unusual Weight Gain/Loss
 Survivor of Emotional or Physical Abuse/Trauma
 Addictive Behaviors
 Drug Abuse
 Sexual Activity
 Sleeping Too Much or Too Little
 Diabetes
 Thyroid
 Headaches
 Seizures
 Personal Finances
 Bankruptcy
 Other:

PLEASE USE BACKSIDE FOR ANY ADDITIONAL INFORMATION