GAINESVILLE FAMILY COUNSELING

Ceres I. Artico, Ph.D.

TODAY'S DATE: _____

CLIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

BUSINESS PHONE: _____ **EMAIL:** _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

MARITAL STATUS: _____

EMPLOYER: _____

POSITION: _____

PERSON(S) LIVING WITH YOU:

NAME	AGE	RELATIONSHIP

CHILDREN NOT LIVING AT HOME (NAMES AND AGES PLEASE):

_____

_____

_____

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REASON YOU ARE SEEKING COUNSELING

PLEASE DESCRIBE THE PROBLEM AND WHEN IT STARTED: _____

HAVE YOU OR ANYONE IN YOUR IMMEDIATE FAMILY BEEN IN THERAPY BEFORE? PLEASE EXPLAIN: _____

SELF/FAMILY MENTAL HEALTH AND MEDICAL HISTORY (INCLUDE MEDICATION/DOSAGE):

ANY CONCERNS WITH YOUR OR YOUR FAMILY'S USE OF ALCOHOL AND/OR DRUGS?

ANY CONCERNS WITH HOW YOU OR YOUR FAMILY EXPRESS ANGER? _____

_____

_____

_____

DO YOU EXPECT TO BE INVOLVED IN LITIGATION? PLEASE EXPLAIN. _____

_____

_____

_____

IN CASE OF AN EMERGENCY, WHO MAY WE CONTACT?

NAME: **RELATIONSHIP:** **PHONE:**

_____

_____

PLEASE CHECK ALL SYMPTOMS YOU ARE EXPERIENCING OR CONCERNED ABOUT:

- ❑ **SADNESS**
- ❑ **EXCESSIVE FEAR/WORRIES**
- ❑ **PAST OR CURRENT TRAUMA**
- ❑ **EXCESSIVE USE OF ALCOHOL**
- ❑ **USE OF STREET DRUGS**
- ❑ **ABUSE OF PRESCRIPTION DRUGS**
- ❑ **SEXUAL FUNCTIONING**
- ❑ **EXCESSIVE SPENDING**
- ❑ **FAMILY OR MARITAL CONFLICT**
- ❑ **FINANCIAL PROBLEMS**
- ❑ **LOSSES**
- ❑ **MEDICAL PROBLEMS**
- ❑ **OTHER:** _____
- ❑ **OTHER:** _____

REFERRED BY: _____

Thank you.