Christine Brown, LMFT
Licensed Marriage and Family Therapist
License #202362

1913 Dutton Drive Suite 306
San Marcos TX 78666
(714) 717-2521

New Client Personal Data

Date _____

Name of client_____Date of Birth_____ Age_____

Name of co-client_____Date of Birth_____ Age_____

Parent's name if minor _____Phone (_____)_____

Home Address _____ City_____ Zip_____

Home Phone (_____)_____Cell (_____)_____Other (_____)_____

E-mail address _____ If married, how many years? _____

Therapist has permission to contact me at my: □ ***Home phone*** □ ***Cell phone*** □ ***E-mail*** □ ***Text to cell***

Occupation of client _____ Company Name_____ How long? _____

Occupation of co-client _____ Company Name_____ How long? _____

In case of emergency, please notify _____ Phone(_____)_____

How were you referred to my office? _____

Please describe your current problem _____

_____

Which of the following do you experience? □ *Insomnia* □ *Loss of appetite* □ *Asthma* □ *Headaches* □ *Phobias* □ *Nausea* □ *Allergies*

□ *Nervousness* □ *Loss of temper* □ *Fatigue* □ *Depression* □ *Constipation* □ *Diarrhea* □ *Over-eating* □ *Mood swings*

Have you been in therapy previously? *YES / NO* If so, was it helpful? *YES / NO* Why or why not? _____

Current medical conditions, including duration and severity_____

_____

Current prescription medications:

Name _____Dosage_____ Frequency_____ Dr._____ Phone_____

Name _____Dosage_____ Frequency_____ Dr._____ Phone_____

Name _____Dosage_____ Frequency_____ Dr._____ Phone_____

Have you ever been hospitalized for psychiatric reasons? *YES / NO* If YES, when and for how long? _____

Have you ever attempted suicide? *YES / NO* If YES, when? _____

Would you like spirituality/religious issues to be part of your therapy? *YES / NO / NOT SURE* Church affiliation?_____

Please be assured that this information is confidential under all the circumstances described in the Informed Consent to Treatment document

Fees are payable at the time of service by cash, check or credit card.