Steve L. Franks, M.A.
Licensed Marriage and Family Therapist
Individual psychotherapy and couples counseling

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CLIENT INFORMATION

For Confidential Use Only

Name _____ Birth Date _____ Today's Date _____

Street Address _____

City, State, Zip _____ Email _____

Phone: Home _____ Work _____ Cell _____
Leave Message? Yes __ No __ Leave message? Yes__ No __ Leave Message? Yes __ No __

Emergency Contact _____
Name, relationship and phone Number

Gender M ☐ F ☐ Race/Ethnicity _____ Religion/Spirituality _____
Relationship Status: Single ☐ Engaged ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed ☐

Family/Household Members (spouse, partner, children, housemates; continue on back if needed)

Name	Age	Gender	Relationship	Living with you?
_____	____	_____	_____	Yes ☐ No ☐
_____	____	_____	_____	Yes ☐ No ☐
_____	____	_____	_____	Yes ☐ No ☐
_____	____	_____	_____	Yes ☐ No ☐

Occupation _____ Employer/School _____ # Years Education ____

Physician's Name _____ Phone _____ Date of Last Exam _____

List medical or mental health conditions, surgeries and treatments within the last five years _____

_____

List any medications, supplements, or herbs used in the past three months (continue on back if needed)

Name	Dosage	Reason	Current?
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐
_____	_____	_____	Yes ☐ No ☐

Who referred you to counseling? _____

What brings you to counseling at this time? _____

_____