

HEATHER CRIMSON, MS, LMFT
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831.236.8518

Date: _____ E-mail address: _____

Name: _____ DOB: _____ Age: _____

Street address: _____

City/state/zip: _____

Cell phone: _____ Home phone: _____

Relationship status: _____ Partner's name: _____

Length of relat. _____ Dates of separation/divorce (if applicable): _____

<u>Children</u>	<u>Age</u>	<u>Custody?</u>	<u>School</u>
_____	_____	_____	_____
_____	_____	_____	_____

Employed by: _____ Position: _____

Referred by: _____ Relationship: _____

Prior psychotherapy:
Name of counselor: _____ Dates of treatment: _____

Name of counselor: _____ Dates of treatment: _____

Physician's name: _____ Phone: _____

Date of last physical exam: _____

Currently under medical treatment? _____ For: _____

List all medications that you take: _____

Major illnesses and injuries: _____ Dates: _____

(continued)

Please check any of the following that apply to you now or have applied in the past:

	<u>past</u>	<u>present</u>		<u>past</u>	<u>present</u>
Headaches	_____	_____	Unable to relax	_____	_____
Eating issues	_____	_____	Difficulty learning	_____	_____
Anxiety	_____	_____	Sexual difficulties	_____	_____
Depression	_____	_____	Frequently tired	_____	_____
Suicidal thoughts	_____	_____	Poor appetite	_____	_____
Chronic pain	_____	_____	Recreational drug use	_____	_____
Alcohol use	_____	_____	Physical abuse	_____	_____
Sleeping problems	_____	_____	Sexual abuse	_____	_____
Nicotine use	_____	_____	Suicide attempt(s)	_____	_____
			Dates:_____		

Spiritual/religious orientation: _____

Ethnic/cultural identity: _____

Reasons for seeking therapy: _____

Any additional information that you'd like me to know: _____

In case of emergency, notify:_____ Phone: _____