# Caley O’Dwyer, MFT

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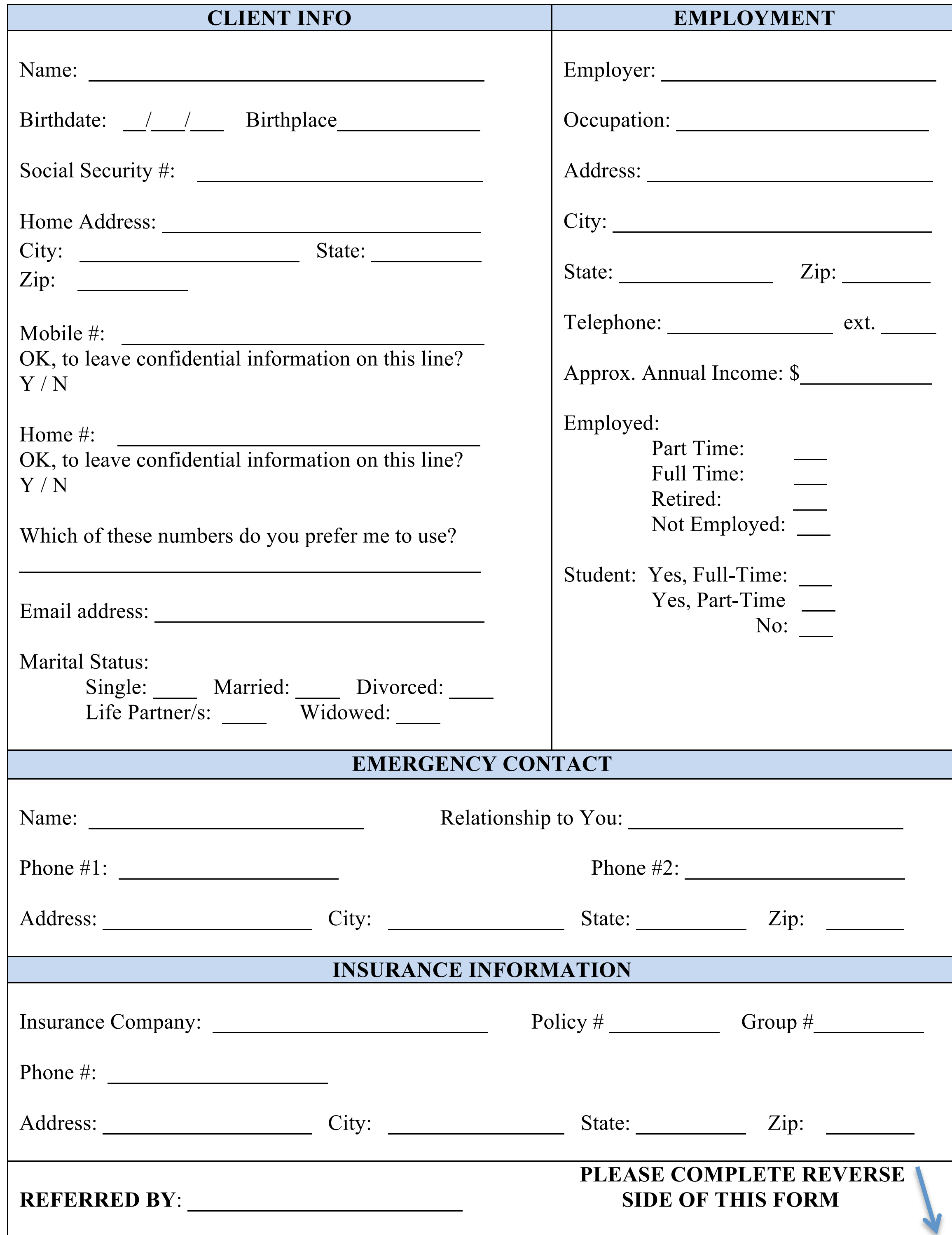
Licensed Marriage and Family Therapist #MFC **52791**

**TODAY’S DATE: ____________**



| CLIENT INFO | EMPLOYMENT |
|---|---|
| Name: ______________________ | Employer: ______________________ |
| Birthdate: __/__/__ Birthplace____________ | Occupation: ______________________ |
| Social Security #: ______________________ | Address: ______________________ |
| Home Address: ______________________<br>City: ______________ State: ________<br>Zip: ________ | City: ______________________ |
| | State: ____________ Zip: ________ |
| Mobile #: ______________________<br>OK, to leave confidential information on this line?<br>Y / N | Telephone: ____________ ext. _____ |
| | Approx. Annual Income: $___________ |
| Home #: ______________________<br>OK, to leave confidential information on this line?<br>Y / N | Employed:<br>Part Time: ___<br>Full Time: ___<br>Retired: ___<br>Not Employed: ___ |
| Which of these numbers do you prefer me to use?<br>______________________ | Student: Yes, Full-Time: ___<br>Yes, Part-Time ___<br>No: ___ |
| Email address: ______________________ | |
| Marital Status:<br>Single: ____ Married: ____ Divorced: ____<br>Life Partner/s: ____ Widowed: ____ | |

**EMERGENCY CONTACT**

Name: ______________________ Relationship to You: ______________________

Phone #1: ______________ Phone #2: ______________

Address: ______________ City: ____________ State: ________ Zip: ______

**INSURANCE INFORMATION**

Insurance Company: ______________________ Policy # ________ Group #________

Phone #: ______________

Address: ______________ City: ____________ State: ________ Zip: ______

**REFERRED BY**: ______________________

**PLEASE COMPLETE REVERSE SIDE OF THIS FORM**

Any Spiritual/Religious Preference:

Have you had any previous counseling/therapy (if yes, please explain):

With Whom?

Father: Living? ____ Age: ____ Occupation: ________________

Mother: Living? ____ Age: ____ Occupation: ________________

Brothers: (How many?) Older ______ Younger _________ Twins _____

Sisters: (How many?) Older ______ Younger _________ Twins _____

## Medical

Primary Care Physician: ______________________________ Phone:____________________________

Psychiatrist: Phone: ______________________________ Phone:____________________________

Any Specific Physical Problems (if yes, please explain):

## Do You Use Any of the Following?

| Medication: | Y/N | Kind | Dosage |
|---|---|---|---|
| Anti-Depressants | | | |
| Appetite Suppressants | | | |
| Sedatives | | | |
| Sleeping Aids | | | |
| Stimulants | | | |
| Anti-Anxiety | | | |
| Laxatives | | | |
| Other Medications? | | | |

## Do You Struggle With?

Nervousness: _____

Shortness of breath: _____

Migraine Headaches: _____

High Blood Pressure: _____

Fainting Spells: _____

Depression: _____