ADAM D. COFFEY, PH.D.

Licensed Marriage & Family Therapist
Licensed Professional Counselor

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GENERAL INFORMATION

(Note: Due to this information's personal nature, you may leave blank uncomfortable areas.)

Name(s): _____

Address:_____e-mail address:_____

Phone number(s):_____

Date(s) of birth: _____Emergency Contact: _____

Social Security Numbers:

Family members (List children, parents, siblings, grandparents, ex-spouses, etc. If needed, continue on the back of this page.)

Names	Ages	Relationship to you	Locations

_____
_____
_____
_____
_____

Medications/Herbs/Vitamins/Supplements:

_____

Diagnosed medical conditions:

_____

Previous mental health experiences, including psychiatrists, psychotherapists, psychiatric hospitalizations, diagnosis(es), etc.:

_____

Primary care physician's name:_____

Previous alternative services (e.g., massage, homeopathy, chiropractor, acupuncture, etc.):_____

Alcohol or other drug problems:_____

Received or given abuse: Yes No

IF "Yes," when, what kind, by whom, and how long?

_____

Religious identification: _____

Education:_____

Income source and amount:_____

Self/Other harm behavior: Yes No

IF "Yes," when and how?

_____

Civil legal matters and/or criminal behavior/arrests/convictions: Yes No

IF "Yes," when and what kind? _____

What specific changes do you intend to make during the process and outcome of our therapy?

_____

_____

_____

_____

_____

_____

Please list any other relevant information you think I should know:

_____

_____

Credit Card Information: Number: _____

Name: _____, Exp. Date: _____, Code: _____

Sleep: _____

Exercise: _____

Diet:_____

Referred by: