MOLLY M. AKIN, LMFT

Individual, Couples & Family Therapy

CLIENT INFORMATION

NAME: ______________________________ DATE: ____________________

DATE OF BIRTH: ______________________ GENDER: MALE FEMALE

ADDRESS: ____

PHONE: ____________________________

OKAY TO LEAVE A MESSAGE? YES NO OKAY TO SEND A TEXT (see practice policies)? YES NO

EMAIL: ____________________________

OKAY TO SEND AN EMAIL(see practice policies)? YES NO

HOW DO YOU PREFER TO BE CONTACTED? ______________________________

OCCUPATION: ____

EMPLOYER (IF STUDENT, PUT SCHOOL): ____________________________

WHO REFERRED YOU? ____

RELATIONSHIP STATUS: single married separated divorced dating cohabitating

WHO LIVES WITH YOU?

Name	Age	Relationship

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS/CONCERNS:

___Headaches	___Nervousness	___Dizziness	___Fainting Spells
___Shyness	___Stomach Trouble	___Relaxation	___Stress
___Anxiety	___Fatigue	___Legal Matters	___Self Control
___No Appetite	___Anger	___Memory	___Making Decisions
___Insomnia	___Nightmares	___Separation	___Energy
___Inferiority	___Take Sedatives	___Drug Use	___Loneliness
___Bowel Troubles	___Marriage	___Use Alcohol	___Allergies
___Suicidal	___Sexual Problems	___Work	___Under eating
___Overeating	___Home Conditions	___Friends	___Concentration
___Temper	___Ambition	___Divorce	___My Thoughts
___Parenthood	___Health Problems	___Age	___Finances
___My appearance	___Future	___Sexual Abuse	___Children
___Career Choices	___Weight	___Unhappiness	___Depression
___Mood Swings	___Fears	___Self-esteem	___Physical Abuse

Sleeping Issues? YES NO Average Number Hours of Sleep Per Night? _________

PAST EXPERIENCES (Check those that apply):

___Death of a spouse/partner	___Marriage Problems	___Divorce
___Death of a family member	___Job dissatisfaction	___Loss of job
___Major illness/injury of self	___Financial issues	___Move to another city or state
___Major illness/injury of relative	___Legal Problems	___Bad break up
___Family Issues (with children/parents/in-laws)		___Other _______________________

PLEASE LIST ANY CURRENT MEDICATIONS: ____

____

HAVE YOU BEEN TO COUNSELING BEFORE? YES NO

IF SO, WHEN AND FOR HOW LONG? ____

WAS IT HELPFUL? PLEASE EXPLAIN. ____

____

REASON(S) FOR SEEKING COUNSELING AT THIS TIME? __________________________________

____

____