

Rev. Robert A. Sisler
3829 Grafton Rd
Morgantown, WV 26508

Phone – (304) 288 – 3555

CLIENT INFORMATION

Please provide the information requested below. This is confidential information and will not be released to anyone without written permission from the client except as noted in the Informed Consent Form.

First Name _____ Last Name _____

Spouse's Name _____ Your Date of Birth _____ Gender M / F

Street Address _____ Apt # _____ PO Box _____

Street Address (con't) _____ Email _____

Zip Code _____ City _____ State _____

Phone Numbers

Home _____ Work _____ Cell _____

FAX _____ Pager _____

What Can We Do For You?

Briefly state the reason that you are seeking a therapist at this time.

Marital Information

Please list all of your significant interpersonal relationships including: Engagement, Marriage, Separation, Divorce, Widow. List each in order.

<u>Year</u>	<u>Relationship Event</u>	<u>Year</u>	<u>Relationship Event</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children

Please list each of your biological children. List them in order of year. Also, list the name of the other parent.

<u>Birth Year</u>	<u>Child's Name</u>	<u>Other Parent</u>	<u>Your Relation to Other Parent</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History: Please give a brief statement regarding:

1. Hospitalizations/Surgeries:

2. Serious Illness/Injury (including head injuries):

3. Chronic Medical Conditions (including allergies):

4. Current Prescriptions/Medications:

5. Physician's Name: _____ **Date of last visit:** _____
Physician's Telephone Number: _____

6. Family History: Any major mental or physical health or drug/alcohol issues.

7. Problems that you feel apply to you and/or a significant other (please indicate whom the problem refers to):

- | | |
|--------------------------------------|---|
| _____ Depression | _____ Alcohol/other drug abuse (self) |
| _____ Suicidal Thoughts | _____ Alcohol/other drug abuse (family) |
| _____ Suicidal Actions | _____ Marital/Relationship Problems |
| _____ Anxiety | _____ Sexual Problems |
| _____ Panic Attacks | _____ Career Choice Concerns |
| _____ Sleep Problems | _____ Sexual abuse, actual or threatened |
| _____ Eating Disorders | _____ Physical abuse |
| _____ Withdrawn behavior | _____ Family violence, actual or threatened |
| _____ Job Related Problems | _____ Death of Loved One |
| _____ Financial Concerns | _____ Compulsive Gambling |
| _____ Parent-Child conflict (self) | _____ Self-esteem |
| _____ Parent-Child conflict (spouse) | _____ Brother/sister problems |
| _____ Parent-Child conflict (both) | _____ School problems |
| _____ Communication problems | _____ Blended family issues |
| _____ Running away | _____ Parental loss of control |
| _____ Legal Difficulties | _____ Other |

8. Prior Therapy or Counseling:

9. Name of Therapist/Counselor: _____

Date last seen: _____

10. Please provide any additional information that you feel is important.

11. Please list the goals you hope to achieve in treatment/counseling (be specific).
