FAMILY INFORMATION FORM

Today's Date:_____

Name:_____ Birthdate:_____ Age:_____

Address:_____
(Street) (City) (State) (Zip)

Phone: home_____ work: _____ cell/pager:_____

Education: highest level completed:_____

Occupation:_____ Spouse's Employer: _____

Current Marital Status: Single Married Separated Divorced Widowed

Spouse's Name:_____ Birthdate:_____ Age:_____

Number of years together:_____ Number of previous marriages: _____

Children: names & ages _____, _____,_____,

_____, _____, _____, _____

Brothers/Sisters: names & ages _____, _____, _____

_____, _____, _____, _____,_____

Religious Affiliation:_____

Who referred you: Physician Friend School Pastor Other_____

Family Physician:_____
(Name) (Address) (Phone)

List any serious illness you have had: _____

_____

List any medication you are taking:_____

_____

Previous psychological services: No Yes Dates:_____

Reasons for previous services:_____

_____

_____

Briefly describe your need for psychological services now:_____

_____

_____