ALLISON D. OSBURN-CORCORAN, MFT

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LICENSED MARRIAGE AND FAMILY THERAPIST
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Today's Date: _____/_____/_____

Last Date of Therapy (approximate) : _____/_____/_____

ABOUT YOU (THE CLIENT):

Your name:_____ Date of Birth:_____/_____/_____ Age:_____

Home Street Address: _____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell:_____

Number you prefer to be contacted:_____ May I call you at work? **Yes** **No**

Best time to reach you at your preferred number:_____

May I contact you via email: **Yes** **No** (You may opt out at anytime; your address is not sold or shared with anyone.)

Email Address: _____

Are you being seen **with** a partner as a **couple**? **Yes** **No**

YOU AND YOUR PARTNER:

Partner's Name:_____ Date of Birth:____/____/_____ Age: _____

Home Street Address: _____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell:_____

Preferred contact number:_____ May I call him/ her at work? **Yes** **No**

Best times to reach him/ her at the preferred number: _____

Are you married? **Yes** **No** Married or not, how long have you been together?_____

Are you divorced/ separated? **Yes** **No** If yes, for how long? _____

Have you ever been separated from your current partner? **Yes** **No** If yes, how long? _____ When_____

PERSON TO CALL IN CASE OF EMERGENCY:

Name:_____ Phone:_____

Relation:_____

YOUR MEDICAL CARE:

Doctor's Name: _____ Phone:_____

Address: _____

Date of your last medical exam: _____/_____/_____

If necessary, may I inform your doctor that you are in treatment with me so that he/she can be fully informed and coordinate your care? **Yes** **No**

MEDICAL HISTORY:

Please describe any present or past major medical problems (e.g., major illness, surgeries, accidents, etc.):

_____

_____

MEDICATIONS:

Are you currently taking any psychotropic medications? (e.g., anti-depressants/ anti-anxiety medications) **Yes** **No**

If yes, What is prescribed? _____ Dosages:_____

Who is the prescriber? **Psychiatrist** or **Primary Care Physician**

Are you presently taking any medications for physical (non psychiatric) problems? **Yes** **No**

If yes, What is prescribed?_____ Dosages:_____

Any regular use of over the counter medications? _____

YOUR CHIEF CONCERN:

Please describe the main difficulty that has brought you in to see me: _____

_____

_____

Estimate the severity of the problem: **Mild** **Moderate** **Severe** **Very Severe**

YOUR GOALS:

What would you MOST like to see happen in your life as a result of coming to see me?_____

_____

_____

What do you MOST want to change about yourself? _____

_____

What do you think or feel is the greatest barrier to creating change in your life right now? _____

_____

AND FINALLY……

Tell me anything more you would like me to know about you and/or the reason you have come to see me today that you think would be essential that I know: _____

_____

_____

Please bring your completed forms to your first session.

Thank you!!