

Olive Branch Counseling Associates, Inc.

Client Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City & State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

How many hours a week do you work? \_\_\_\_\_ Employer or School \_\_\_\_\_

Spouse \_\_\_\_\_ Occupation: \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Would you like your therapist to contact your physician? \_\_\_\_\_ Phone # \_\_\_\_\_

Have you seen a therapist before? \_\_\_\_\_ How long ago? \_\_\_\_\_ For how long? \_\_\_\_\_

Name of Therapist: \_\_\_\_\_

Do you have any diagnoses made by a physician or therapist? \_\_\_\_\_ With what have you been diagnosed? \_\_\_\_\_

Please list any medications you take: \_\_\_\_\_

Names and Ages of Siblings \_\_\_\_\_

Is your mother living? \_\_\_\_\_ If not, cause of death? \_\_\_\_\_

Is your father living? \_\_\_\_\_ If not, cause of death? \_\_\_\_\_

How do you describe yourself culturally/ethnically? \_\_\_\_\_

Have there been any changes in your life recently? (death of a loved one, divorce, etc.)  
\_\_\_\_\_

What kinds of difficulties bring you to our office? \_\_\_\_\_  
\_\_\_\_\_

Is there anything else you want your therapist to know about you right now?  
\_\_\_\_\_

Please tell us how you found Olive Branch: \_\_\_\_\_