

Molly Richter, LMFT, LLC  
Client Information (Minor)

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_ Client Acct #: \_\_\_\_\_

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_ Zip: \_\_\_\_\_ Address of: **mother father self other**: \_\_\_\_\_

Home phone: \_\_\_\_\_ Okay to leave messages? Yes or No

Cell phone: \_\_\_\_\_ Okay to leave messages? Yes or No

Email address: \_\_\_\_\_

Other Address if app. \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_ Zip: \_\_\_\_\_ Address of: **mother father self other**: \_\_\_\_\_

Home phone: \_\_\_\_\_ Okay to leave messages? Yes or No

Cell phone: \_\_\_\_\_ Okay to leave messages? Yes or No

Email address: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian phone #(s): \_\_\_\_\_ email: \_\_\_\_\_

In case of emergency you have my permission to contact: \_\_\_\_\_

Contact #(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

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Insurance Subscriber Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address if different: \_\_\_\_\_

Employer: \_\_\_\_\_ City: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name: \_\_\_\_\_

Marital Relationship Status			
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Significant other	If married or significant other, how long _____
<input type="checkbox"/> Cohabiting	<input type="checkbox"/> Engaged	<input type="checkbox"/> Divorced	
<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Remarried	
Spouse/Partner:			
All Who Live in your Home:			
Name	Age	Relationship to you	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Siblings/ages (if not living in home):			
Prior Marriage/Significant Partners:			
Name	Year of separation & divorce	Names of Children	Live with you(Y/N)
Past Counseling Experience: Yes _____ No _____			
When and Brief Characterization of Your Experience:			
Past Diagnoses? (We will discuss whether you agreed with these diagnoses)			
Current medications?			
Reasons For Seeking Counseling Now:			

## Physical Health Information

Name: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Last physical: \_\_\_\_\_

Do you have any major medical illnesses (such as heart disease, diabetes, arthritis, asthma, kidney disease, liver problems, history of cancer) or current health concerns?

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Current medication(s), amount/dosage, how often, for what condition:

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Additional medications purchased at the store (pain relievers, digestive aids, sleep aids, vitamins, etc.)?

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Any additional information you would like to add? Feel free to add below!

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