Molly Richter, LMFT, LLC
Client Information – Couple

Date: _____ Referred by: _____ Client Acct #: _____

Name: _____ DOB: _____ Age: _____

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: ____ Zip: _____

Other Address (if applicable): _____

City: _____ State: ____ Zip: _____

Home phone: _____ Okay to leave messages? Yes or No

_____ Cell phone: _____ Okay to leave messages? Yes or No

_____ Cell phone: _____ Okay to leave messages? Yes or No

Email address(es): _____

_____

In case of emergency you have my permission to contact:_____

Contact #(s): _____ Relationship: _____

Insurance Subscriber Name: _____SSN: _____

Address if different: _____

Employer: _____ City: _____

Primary Insurance: _____ Group #: _____ Policy #:_____

Secondary Insurance: _____Group #: _____ Policy #:_____

Name: _____

Marital Relationship Status

___ Single ___ Married ___ Significant other If married or significant other, how long _____
___ Cohabiting ___ Engaged ___ Divorced
___ Separated ___ Widowed ___ 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:

Name: _____

Marital Relationship Status

___ Single ___ Married ___ Significant other If married or significant other, how long _____
___ Cohabiting ___ Engaged ___ Divorced
___ Separated ___ Widowed ___ 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?

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

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

_____

_____

_____

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