Christie S. Jones, M.A., L.P.C., B.C.P.C.
Licensed Professional Counselor

IDENTIFYING INFORMATION:

Name_____DOB_____

Address_____

Phone #: H_____W_____C_____
Is it okay to call these numbers? If not, please indicate by circling.

Nearest friend or relative we may contact in case of emergency:

_____
Name Relationship Phone

Marital Status: Married__Single__Divorced__Other__

Place of Employment_____

Occupation_____

How long have you been with this employer?_____

Name, age, and sex of children, if applicable:_____

_____

How did you hear about our services?_____

May we thank your referral source?_____

Have you received mental health care recently?_____

If so, who was your health care specialist?_____

What did you address with him?_____

_____

What would you like to address today?_____

_____

Describe any major medical/physical problems:_____

_____

List known allergies_____

Primary Care Physician_____Phone_____
Address:_____
Date of last visit_____

Psychiatrist, if applicable_____Phone_____
Address_____
Date of last visit_____

List all prescription medications you are currently taking:

Medication	Daily Dose	Prescribing Physician	Condition	Starting Date