G. Pat Stogner, M.Ed.

Licensed Marriage and Family Therapist

PERSONAL INFORMATION

Name: _____ Date: _____
Age: _____ DOB: _____
Home Address: (street) _____
(city) _____ (state) _____ (zip) _____
(May we contact you by mail? ☐ yes ☐ no)

List any numbers by which we may contact you. If couples therapy, list for both people.
Home phone: _____
Work phone: _____
Cell phone: _____
Email: _____

Household Members:
Name: _____ Age: _____ Relationship: _____
Name:_____ Age: _____ Relationship: _____
Name:_____ Age: _____ Relationship: _____
Name:_____ Age: _____ Relationship: _____
Name:_____ Age: _____ Relationship: _____

List any medications you are presently taking.

Medication:	M.D. prescribing:	Why prescribed?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Counseling:

Dates seen:	Why seen?	Helpful?
_____	_____	☐ yes ☐ no
_____	_____	☐ yes ☐ no