

General Information			
<b>Name:</b>			
<b>Address:</b>			
<b>City:</b>		<b>State:</b>	<b>Zip Code:</b>
<b>Phone – Home:</b>	(____) _____ - _____	<b>Cellular:</b>	(____) _____ - _____
<b>Work:</b>	(____) _____ - _____	<b>Fax:</b>	(____) _____ - _____
<b>Email Address:</b>			
<b>Marital Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>If married, how many years?</b>		<b>If divorced, how many years?</b>	
<b>Have you ever been in counseling?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes – If yes when?		
<b>Are you now in counseling?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, how long?		
<b>With whom are you counseling?</b>			
<b>If you were referred, by whom?</b>			
<b>Briefly describe what you would like to accomplish in counseling:</b>			
_____			
_____			
_____			
<b>Briefly describe your original family.</b>			
_____			
_____			
_____			
<b>Do you regularly use legal or illegal medications? Alcohol?</b>			
<input type="checkbox"/> Yes <input type="checkbox"/> No    Describe:			
<p>By my signature below, I agree that I am committed to coming and working on my individual issues. Also, I understand that it is required that I not bring other family members with me to this appointment unless it is suggested by LFEM or I am a parent coming with my child/teen.</p>			
<b>Signature:</b> _____		<b>Date:</b> ____/____/____	

**For LFEM Use Only: Date Received:** \_\_\_\_/\_\_\_\_/\_\_\_\_