

C a r o l A m b r o s e, L C P C
65 Thomas Johnson Drive, Suite A, Frederick, MD 21702
55 Adclare Road, Room 220, Rockville, MD 20851
Telephone (301) 667 6327

New Clients: *Please complete and bring to first session.*

PERSONAL INFORMATION

Client Name _____ Today's Date _____

Birth date(s) _____ Age(s) _____

Street Address _____

Phones: H _____ C _____ Best times to call _____

Email Address (optional) _____

(This will not be shared).

Marital Status: Single ___ Engaged ___ Married ___ (When?) _____

Widowed ___ (When?) _____ Divorced ___ (When?) _____

Education _____ Occupation _____

Currently Employed? _____

Religious Affiliation? _____

Prior Counseling? Yes _____ No _____

Household Members— include age and relationship:

Emergency Contact *(name, relationship, address, phone numbers including cell):*

Nature of the problem to be addressed in counseling;

Most difficult relationship right now:

CRISIS INFO: Any past or present suicidal thoughts, feelings, or actions? If so, please explain:

Any current violent (including homicidal) thoughts or feelings? Anger-control problems?

Is there a threat to you of significant harm or loss? Explain.

MEDICAL INFO:

Your primary physician's name, address, phone

List medical conditions:

List all medications you are taking:

Have you ever been hospitalized for mental health reasons?
If so, diagnosis?

Anything else important for your therapist to know?

_____Signature_____Date