Patient Information Form

LiveWell Therapy Services, LLC

Name:___________________________________

Previous or Maiden Name:__________________________________

DOB: _____________

SS#______-_____-_________

Address

Street:

City:

State:

Zip Code:

May we contact you by mail: YES NO

Phone Numbers

Cell:

Home:

Work:

Which phone number(s) do we have your permission to contact you at for communication regarding appointments?

(Please Circle)

Cell Home Work

Do we have permission to leave a message at this number?

May we text you on your cell phone regarding appointments or cancellations?

If you wish to communicate via e-mail please provide an e-mail address

Please list individuals we may contact in case of emergency?

Full Name/Relationship:

____

Phone numbers: ____________________

____

Full Name/Relationship:

____

Phone numbers: ____________________

____

Full Name/Relationship:

____

Phone numbers: ____________________

____

Do you work, have a vocation, or volunteer outside the home: Yes No

Please describe:

Are you currently a caregiver for a family member(s) or someone in the community: Yes No

Please describe:

Employment History

Current Profession:

Title/Responsibilities:

Employer/Name of Business:

Current Status: Full-Time Part-Time Unemployed

Past Profession/Vocation/Interests:

Educational History

Education (level completed/current grade)______________

Grade average: __________

GED: **Yes** **No**

Current School:____

Names of schools/colleges attended:

____

____

____

____

____

____

____

Program of Study:______________________________

Major/Minor:____________________________________

Military History

Did you serve in the military: YES   NO

What branch of the military? ____

Date discharged: ____________

Type of discharge: ____________

Where did you serve?

____

____

____

____

How long did you serve?

____

____

____

Do other family members serve?   YES   NO

Comments:____

____

____

Relationship Status: (Please Circle)

New relationship **Long-term commitment** **Engaged**

Married **Separated** **Divorced** **Partner loss** **Widow/Widower**

Members of Your Household:

Full Name:

Relationship:

Age:

Full Name:

Relationship:

Age:

Full Name:

Relationship:

Age:

Full Name:

Relationship:

Age:

Full Name:

Relationship:

Age:

Full Name:

Relationship:

Age:

Primary subject matter or concern(s) that bring you to counseling?

____

____

____

____

____

____

What changes do you want to see as a result of counseling?

____

____

____

____

____

Have you participated in counseling before?

____

____

____

How long:______________________

What brought you to counseling in the past?

____

____

Were you pleased with the experience?______________________________________

____