Nanci Brown, LCSW-C
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Name: Today's Date:

Street: City: State:

Zip: Home Phone: Cell Phone:

Employer: Work Phone:

Email:

*Please indicate the best number to reach you at or best way to contact you

Can I leave a message identifying who I am? Yes No

Work Address: Occupation:

Sex: *Male Female* Ethnicity: Date of Birth: Age:

Marital status (circle all that apply): *Single Engaged Living together Married Separated Divorced Widowed*

Name of Partner: Partner's Employer:

E-mail: Referred by:

Names of Children:	Age	Gender	Living w/ you?	Comments:
		M F	*Yes No*	
		M F	*Yes No*	
		M F	*Yes No*	

Briefly state your reason for seeking counseling at this time:

Have you or a family member ever been seen by a mental health professional before? *Yes* *No* If yes, please indicate who, when and why:

Do you regularly practice relaxation techniques (e.g. meditation, yoga, Tai Chi)? *Yes* *No*

If yes, what and how often?_____

How often do you get 20 minutes or more of exercise? _____

Do you smoke? If so, how much each day?_____

How much alcohol do you usually drink? _____

Do you use "recreational" drugs? *Yes* *No* If yes, what and how often? _____

_____

Who is your primary physician? Phone #:

Who is your OB-GYN? Phone #:

Please list any troublesome or significant medical conditions you may have.

Please list your current medications (Prescription & Non-Prescription):

Drug	Dose	Frequency	When Started	For what symptom(s)	Prescribing Doctor

Who should be notified in case of emergency?

Name: Relationship:

Home Phone: Work Phone: Cell:

Briefly describe your pregnancy and labor and delivery (including any complications or unexpected events).

Have you, or an immediate family member, ever suffered from depression? If so, when, and what did treatment entail?

Was this child planned? *Yes* *No*

Was conception assisted? *Yes* *No*

If yes, what interventions were used?

What social supports do you have right now? *Friends Family (in town) Family (out of town*