Mary Deger Seevers, MA, MFT
Licensed Marriage & Family Therapist

Client Information Form

Today's Date:________________________Client Number:______________________________

Social Security Number:______________________ Referred by:_______________________

Name:_________________________________Age:__________Date of Birth:_____________

HomeAddress:____

City:____________________State:_____Zip:___________Driver's License#:___________

Telephone(s) home:___________________work:________________cell:________________
Star* the phone number you would prefer I leave a confidential message
Email: _______________________fax:_________________________other:_____________

Insurance Company:______________________________ID#:_________________________

Ins. Co. Address:____

Social Security Number:____

Your Employer:_________________________Your Occupation:_________________________

Length of Time Employed at current position:__________Position Title:_________________

Relationship status:______________ Length of Time Together:________

Partner/ Spouse's Name:________________Age:___ Partner's Telephone(s):_______________

Spouse's Employer:______________________________Occupation:_______________________

Person & Number to call in case of emergency (if different than above):___________________

Relationship to you:____
Family members and others living in your home-Name/Relationship to you:

____Age:______

____Age:______

____Age:______

669 Crespi Drive Suite J Pacifica, CA 94044

Tel: 650-655-2718 Fax: 650-355-7135

Your Parents/Step-Parents (name/age or year of death):

____Location:_________________

____Location:_________________

Clinic/Doctor's name:_____________________________________Phone:_________________
Address:____
Last visit:__________________ _____Please list out for me all of your current medication(use the back of this page if necessary)____
____
____

If you enter counseling with me ,may I tell your medical doctor so that he or she can be fully informed and we can coordinate treatment? Yes___No___if no, why not?_________________
____

Have you been in therapy before?___________If yes, approximately how many visits did you have with the therapist?_____less than a month______less than a year_____a year or more
Briefly state your reasons for seeking treatment:
____
____
____
____
____

Check any of the following that apply to you at this time:

___Headaches	___Alcohol Consumption	___Obsessive Thoughts
___Dizziness	___Feel Tense	___Shy Around People
___Fainting Spells	___Feel Panicky	___Lack of Friends
___Palpitations	___Tremors	___Loneliness
___Stomach Trouble	___Depression	___Indecisive
___Change in Appetite	___Suicidal Ideas	___Job Related Problem
___Bowel Disturbances	___Use of Drugs	___Inferiority Feelings
___Chest Pains	___Unable to Relax	___Financial Difficulties
___Fatigue	___Sexual Problems	___Feelings of Being Afraid
___Insomnia	___Uninterested in Vacations	___Compulsive Behavior
___Nightmares	___Fear of Leaving Home	___Unhappy Home Environment
___Use of Sedatives	___Over-Ambitious	

Do you drink alcohol?_____ Weekly usage (approx.):_____________Smoke Cigarettes?______

Is there anything not mentioned above that you think I ought to know:___________________

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