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Individual/Family Information

Name _____ Date of Birth _____
Gender: Male Female Education completed _____ Religion (optional) _____
Occupation _____ Employer _____
Home Address _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.
Spouse/Partner's Name _____ Date of Birth _____
Gender: Male Female Education completed _____ Religion (optional) _____
Occupation _____ Employer _____
Home Address (if different from above) _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.

Individual/Family combined annual income (circle one)
\$10-19,999 20-35,999 36-49,999 50-75,999 76-99,999 100-125,000 125,000+

Number of marriages (including current) for you _____ Your partner _____
Years of current marriage/relationship _____

Please list below all children from this or previous marriages/relationships whether or not they live in your household.

Table with 3 columns: Name(s), Age, Gender. Includes horizontal lines for data entry.

Please list below any medication(s) members of your family are currently taking.

Table with 3 columns: Name, Medication, Dosage. Includes horizontal lines for data entry.

Medical Concerns:

Name of Physician: _____ Phone: _____

Date of last physical: _____

Current Service Providers: _____

Are you willing to sign a release of information for me to coordinate care with them?: yes no

Any Past Service Providers (therapists, psychiatrists, etc.):

Are you willing to sign a release of information for me to coordinate care with them?: yes no

Has anyone being seen ever abused drugs? Yes No If yes, who and which drugs:

Please list below any physical or emotional health problems that members of your family have suffered now or in the past (Include relevant extended family such as parents).

Name *Physical or Emotional Health Problem*

Has any member of your family ever participated in counseling or therapy? Yes No

Who? _____

Reason(s)? _____

What led you to end counseling or therapy? _____

Please check any of the following that have been an issue with individuals or relationships in the family:

- | | | |
|---|--|--|
| <input type="radio"/> Drinking Problem | <input type="radio"/> Sexual Problems | <input type="radio"/> Chronic Stress |
| <input type="radio"/> Drug Problem | <input type="radio"/> Physical Abuse | <input type="radio"/> Controlling or verbal abuse |
| <input type="radio"/> Depression | <input type="radio"/> Physical Aggression (pushing, slapping, etc) | <input type="radio"/> Parenting Stress |
| <input type="radio"/> Anxiety | <input type="radio"/> Financial Difficulties | <input type="radio"/> Acting out Children |
| <input type="radio"/> Disordered Eating | <input type="radio"/> Suicide attempts | <input type="radio"/> In-Law or extended family problems |
| <input type="radio"/> School Problems | <input type="radio"/> Legal Problems | |
| <input type="radio"/> Sexual Abuse | | |

What brought you in today?

What are your goals for therapy?

How did you hear about me?

Signature of person filling out form: _____ Date: _____