



Sean Davis, PhD

LICENSED MARRIAGE AND FAMILY THERAPIST, MFC 45885
COUNSELING FOR INDIVIDUALS, COUPLES AND FAMILIES

1380 Lead Hill Blvd, Suite 160
Roseville, CA 95661

(916) 844-4615
sean@drseandavis.com

Individual/Family Information

Name _____ Date of Birth _____
 Gender: Male Female Education completed _____ Religion _____
 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 _____
 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)
 \$0-49,999 \$50-74,999 \$75-99,999 \$100-124,999 \$125-149,999 \$150,000+

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.

Name(s)	Age	Gender
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name	Medication	Dosage
_____	_____	_____
_____	_____	_____

Medical Concerns: _____

Physician: _____ Phone: _____

Date of last physical: _____

Past Mental Health Service Providers (therapists, psychiatrists, etc.):

Are you willing to sign a release 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:

- Drinking Problem
- Drug Problem
- Depression
- Anxiety
- Eating Disorder
- School Problems
- Sexual Abuse
- Sexual Problems
- Physical Abuse
- Sexual Addiction
- Financial Difficulties
- Suicide attempts
- Legal Problems
- Chronic Stress
- Controlling or verbal abuse
- Parenting Stress
- Acting out Children
- In-Law or extended family problems
- Physical Aggression (pushing, slapping, etc)

What are your goals for therapy?

How did you hear about me? _____

Signature of person filling out form: _____ Date: _____