Earl Friesen, M.A., LMFT - Life Skills Plus, Inc.

Welcome - Please fill out the following information

CLIENT INFORMATION

Name (Last, First, MI) Date

Address City/State Zip Phone E-mail address

Birth date Age Place of Birth Race SSN #

Responsible Party (If a minor) Highest grade completed Degree earned Field of Study

Father:	Father's Age	Mother:	Mother's Age

Children's Names	Age	Child's Symptoms:	School/Address

Marital Status: ________ Marriage Date: ________ Spouses Name: ________ Separated? ____ Divorced? ________

Nearest Friend or Relative: ________________ Phone #: ________

Address: ________________

Father's Employer: ________ Employer's Address: ________
Mother's Employer: ________ Employer's Address: ________
Father's Position: ________ Phone: ________ Mother's Position: ________ Phone: ________

PREVIOUS COUNSELING

Previous Counselor: Counselor's Phone #:

Counselor's Address:

Date(s)	Diagnosis	Interventions (level of care)	Response

What did you like most about your previous therapy? ________________

What did you like least about your previous therapy? ________________

What therapeutic style is most helpful to you? ________________

What is the MOST important quality in a relationship? ________________

What is the WORST quality in a relationship? ________________

What do you need most from therapy? ________________

10 Boulder Crescent, Colorado Springs, CO - 80903 - 719.471.1225 - Office@lifeskillsplus.com

MEDICAL INFORMATION

Should you need further room for any question, please use the back of this form and indicate "Back"

Medical Doctor: Doctor's Phone #:

Doctor's Address

Last physical exam: ____________________

GENERAL MEDICAL INFORMATION

Health Problems: ____________________

Surgeries: ____________________

Serious Accidents: ____________________

Allergies: ____________________

Psychotropic Medications	Dosage	Schedule	Route	Start Date	End Date

Name & Phone # of prescribing physician for above medications:

Name: ____________________ Phone #: ____________________

List **PAST** Psychotropic Medications Used: or ______ None

Inpatient Care: ____________________

Substance abuse: ____________________

Current Drugs used ____________________

Past drugs used: ____________________

Cigarettes ____________________

Alcohol ____________________

Previous Treatment: ____________________

Referred By?; ____________________

Presenting Problem: ____________________

Why Now? ____________________

Current Symptoms: