Southwest Psychotherapy Associates
2500 Wilcrest, Suite 401 Houston, TX 77042
832-333-3030

GENERAL CLIENT INFORMATION

Date: _____

Client Name:

_____
LAST FIRST MIDDLE

Age: _____ Date of Birth: ____/____/_____

Male:_____ Female:_____ Ethnicity:_____

Home Address:

_____
STREET CITY STATE ZIP

Phone:

_____
HOME CELL WORK

Do you give this office consent to mail information to your home address?
Yes _____ No _____

E-mail addresss:_____

Marital Status: (Please circle one)

Single Engaged Married

Committed Partnership Separated Divorced Widow(er)

Spouse/Partner's Name: _____

Spouse/Partner's Date of Birth or age: _____

If married, what is your date of marriage? _____

If in a committed relationship, how long have you been together? _____

If divorced or separated, when did this take place? _____

Please list dates of prior marriages, committed relationships, divorces, separations, or annulments.

_____
_____
_____
_____

Please list everyone currently living in the household:

Name	Age	Employment/School	Relationship

Please list any children you have who do not live in the household with you:

Name	Age	Employment/School	Relationship

What is your highest level of education achieved?_____

What is you occupation: _____

Current Employer: _____#Years_____

Work Address:

_____
STREET CITY STATE ZIP

Previous Employer: _____#Years_____

Do you hold religious/spiritual beliefs? Yes_____ No _____

If yes, please explain? _____

Are you in the military? Yes_____ No _____ If yes, Active Duty _____ Reserves _____

If yes, what branch of the military are you in? _____

Are you a veteran? Yes_____ No _____

If yes, in what branch of the military did you serve? _____

Name and phone number of Primary Care Provider and/or Family Physician:

_____

NAME PHONE NUMBER

Please list any chronic health conditions:_____

_____

_____

_____

_____

Name and phone number of Psychiatrist:

_____

NAME PHONE NUMBER

Current Medications:

Name	Dose	Purpose

Previous/Current Mental Health Diagnosis:

Current Health Insurance Company_____

Who referred you to this office? _____

Do I have your permission to thank the referral source for referring you?
Yes_____ No_____

Reason for referral?

_____
_____
_____

What are you seeking to get out of participating in psychotherapy?

_____
_____
_____

_____ _____
Client Signature Date

_____
Print name of Client

_____ _____
Parent/Legal Guardian Signature Date

_____
Print name of Parent/Legal Guardian

_____ _____
Signature of Therapist Date