



Garden City Marriage & Family Therapy

520 Franklin Avenue, Suite 213

Garden City, NY 11530

(516) 248-0580

www.gardencitymft.com

WELCOME To Our Practice

Individual Form

Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Referred by: _____ Can we thank them for the referral?
____yes ____no

Occupation: _____ Birthdate: _____ Age: _____ Sex: _____

EMERGENCY CONTACT (name/tel #): _____

Have you ever been married? ____yes ____no If yes, to whom and for how long? _____

Do you have any children? ____yes ____no If yes, please list below (name & ages):

Is there any other person (besides spouse/children) living in your household: ____yes
____no

If yes, please give their names and their relationship to you

Counseling History

Dates: From: _____ To: _____

With Whom? _____

For What? _____

Who is your Physician? _____

Basic Health: ____good ____fair ____poor When was your last physical exam? _____

Have you ever been hospitalized? ____yes ____no If so, for what? _____

Are you taking any medication at this time? ____yes ____no If yes, what? _____

Are you taking any over-the-counter medications, herbs, supplements, etc.? ____yes ____no If yes, what? _____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? ____yes ____no If yes, what? _____

CURRENT REASON FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling? _____

What would you like to see happen as a result of counseling?

The thing which concerns me the most right now is? _____

Would you like to be added to our mailing list? ____yes ____no

POLICY

IT IS CUSTOMARY TO PAY YOUR THERAPIST AT EACH SESSION.

A COUNSELING SESSION IS NORMALLY 45 MINUTES.

24-HOUR CANCELLATION NOTICE IS APPRECIATED; OTHERWISE 50% OF THE FEE WILL BE CHARGED.

I UNDERSTAND THAT SUICIDAL THREATS, HOMICIDAL THREATS OR CHILD ABUSE BY AN ADULT TO A CHILD WILL BE REPORTED.

I UNDERSTAND AND GIVE PERMISSION TO MY THERAPIST TO SEEK CLINICAL SUPERVISION OR CONSULTATION ABOUT MY SITUATION WHEN NECESSARY.

Signature: _____

Please print name: _____

Date: _____