

PAMELA J. FIRLE, M.A., L.P.C.

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512-784-7770

CLIENT INFORMATION

Date _____ Name: _____

Mailing address: _____

Date of birth: _____ Age: _____

Phone: _____ Text Y N Alt Phone: _____

E-mail: _____

Employer: _____ Spouse or Parent's Name: _____

Marital Status: single__ married__ separated__ divorced__ domestic partners__ widowed__

Children or others living in your home: _____

Responsible Party (if parent, by divorce decree): _____

How did you find my practice? _____

Presenting Problem - Please check all that apply

Alcohol	_____	Anxiety	_____	Legal issues	_____
Drug abuse	_____	Sleeping habits	_____	Crime victim	_____
Sexual abuse	_____	Eating habits	_____	Death/grief	_____
Depression	_____	Fear	_____	Divorce	_____
Suicidal	_____	Anger	_____	Marital issues	_____
Violence	_____	Guilt	_____	Other	_____

Describe "other:" _____

Describe duration of problems: _____

Past counseling experience: _____

Current medications: _____

Nutritional supplements: _____

Known medical conditions: _____

Regular exercise/movement: _____

Describe your support system: _____

What is your spiritual orientation? _____

Do you participate in a community of faith? _____

Name of current physician: _____

Psychiatric hospitalizations: _____

Please complete if you will be filing a claim with your insurance company:

Insurance Company: _____ Policy Holder: _____

Relationship: _____ Social Security #: _____