MARIANNE BINGHAM ROWE, M.S.

529 CENTRAL AVE., SUITE 208
PACIFIC GROVE, CA 93950
(831) 373-1017

MARRIAGE AND FAMILY THERAPI
CA LICENSE NO. MFC 220

Client Information Form

Name: _____ Date: _____

Birthdate: _____ Age: _____ Place of birth: _____

Address: _____ City: _____ Zip: _____

Phone: Home: _____ Work: _____ How long lived in area: _____

Who lives in home (name, relationship and age): _____

_____

_____

Where employed (client and/or parents): _____

_____

Person to contact in case of emergency: _____ Phone: _____

Educational information: (If client is child: name of school, principal, teacher, grade, any remedial/special classes.
If adult: highest grade completed, name and location of school.)

_____

_____

Physician: _____ Physical Problems: _____

_____ Medications: _____

Please circle any of the following that apply:

Headaches	Unable to relax	Blackouts
Heart palpitations	Difficulty in reading	Fainting spells
Shortness of breath	Difficulty in writing	No appetite
Tension and anxiety	Difficulty in math	Sleep problems
Depression	Sexual difficulties	Nightmares
Fearful/shy	Drugs or alcohol	Tiredness
Distractible/short attention span	Temper outbursts	Easily frustrated

Any major accidents, illness, or injuries: _____

Previous counseling: With whom: _____ Approximate dates: _____

Summary of Previous Counseling: _____

_____

Issues/problems that bring you to therapy now: _____

_____

Referred by: _____ ☐ ☐