Susan Morrow, MSW, LCSW 1018 East Blvd Charlotte, NC 28203 704-332-5153

Name_____ Date of Birth_____ Today's Date_____

Name_____ Date of Birth_____

Address_____

Home phone_____ Cell phone_____ Email_____

Home phone_____ Cell phone_____ Email_____

Marital Status____ Education_____ Profession/Employer_____

Who referred you?_____ May we thank them?_____

Previous counseling or treatment, inpatient

or outpatient therapy_____

What changes do you hope that therapy will lead to?_____

_____

What are your strengths?_____

_____

Is there anything important that you feel I should know about?_____

_____

Medical Problems or Family History of Illness_____

_____

Current Medications_____

Chemical Dependency Treatment? Date/Facility_____

Name of Primary Care Physician_____

I authorize Susan Morrow, LCSW to notify my Primary Care Physician that I have started therapy. Communication will include diagnosis and treatment focus. Yes_____ No_____

_____(Patient signature)

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