Mindful Balance Therapy Center

Last Name ________________________ First Name ____________________ Middle Initial ______

Mailing Address _______________________________________ City __________________________

State ______ Zip Code ___________ Email Address ____

Employer Name ______________________________ Occupation _____________________________

Home Phone _________________ Work Phone _________________ Cell Phone________________

Date of Birth _______________________ Social Security # __________________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Care Physician Name & Phone #____

Emergency Contact _______________________________ Phone _____________________________

How did you hear about my practice? ____

What brings you here today? ____

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Have you or anyone in your immediate family ever been to counseling before? ☐ Yes ☐ No

Who	Time Period	Counselor	Reason

Have you or anyone in your immediate family had a psychiatric inpatient hospitalization? ☐ Yes ☐ No

Who	Time Period	Hospital	Reason

Current Medications ____

Psychiatric/Medical Diagnoses (note whether current or past) ______________________

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Please note any safety concerns, including domestic violence or thoughts of harming self or others

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Do you drink alcohol? ☐ Yes ☐ No If yes, how many times do you drink per week? ________

When you do drink, how many drinks do you have (one drink means 12 oz. of beer, 5 oz. of wine, or 1.5 oz. of hard alcohol)? __________

Do you use recreational drugs? ☐ Yes ☐ No If yes, what type and how often? ____________

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Please note any other information that you think would be helpful ____________________

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