

CLIENT INFORMATION

Name _____ Date _____

Address _____ Birth date _____

_____ ZIP _____

Telephone (Home) _____ (Work) _____

(Cell) _____ E-Mail _____

If Employed, By Whom? _____

Position/Type of Work _____

Level of Education/Degrees
Held _____

FAMILY (-IES) IN WHICH YOU GREW UP

Name Relationship Age Marital Status

CURRENT FAMILY/HOUSEHOLD

Name Relationship Age Marital Status

Personal Physician _____

Other Health Professionals Treating You:

Medications you currently take: _____

What is your current use of the following (Circle either N, S, F, or D:
N=Never, S=Sometimes, F= Frequently, D=Daily):

ALCOHOL	N S F D
CAFFEINE	N S F D
ASPIRIN/ASPIRIN SUBSTITUTE	N S F D
LAXATIVES	N S F D
NON-PRESCRIP. SLEEPING PILLS	N S F D
VITAMINS	N S F D
NON-PRESCRIP. ANTIHISTAMINES	N S F D
OTHERS (Please specify)	

_____ N S F D

_____ N S F D

Type and amount of physical activity and exercise:

What interests or hobbies do you have outside of work?

What, if any, is your religious affiliation or spiritual practice?

Have you been in psychotherapy or counseling before? If so, when, for how long and with whom?

Are you covered by insurance for psychotherapy? _____

If so, who is your provider? _____

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