

Wendy Boyer LMFT, LLC

Wendy Boyer Wahlquist: *Marriage and Family Therapist*
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CLIENT INFORMATION FORM

Date: _____

Basic Demographic info:

Name of person completing form : _____ Relationship: _____

Identified Client name: _____

Social Security No.: _____ Date of Birth: _____

Address: _____

Telephone Nos.: (H) _____ (W) _____ (C) _____

Other Telephone No: (h) _____ (w) _____ (c) _____

emails: _____

Insurance info:

Insured Name: _____ SSN: _____ Date of Birth: _____

Insurance: _____ Insurance ID: _____ Group #: _____

Deductible: _____ CoPay: _____

Emergency Information:

Name of Emergency Contact: _____

Phone(s): _____

Relationship to Patient: _____

Primary Care Physician, Pediatrician, Psychiatrist: _____

Phone: _____

Identified Client Information:

Check as many
as apply:

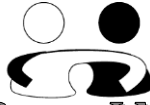
Committed Relationship _____	Single _____
Divorced _____	Separated _____
Widowed _____	Other _____

Highest level of education attained: _____

Employer: _____ Occupation: _____

School (for children, and adults when applicable): _____

Guardianship (for children and adults when applicable): _____



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Name of partner, child/children:	Age:	Date of birth:	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Health History:

Have you ever been involved in therapy or any other type of counseling program? Yes No

If yes, when? _____ Where? _____

Reasons: _____

Reasons for considering counseling at this time: _____

Were you referred to this counseling office? Yes No If yes, by whom? _____

Are you in treatment with another counselor presently? Yes No

If yes, with whom? Name: _____ How long? _____

Have you ever taken medications for mental health reasons? Yes No

If so, please list, with any side effects: _____

Are you currently prescribed any medications? Yes No Please list: _____

Name of prescribing physician: _____ Phone: _____

Have you ever been hospitalized for any mental health reason? Yes No

If yes, when? _____ Where? _____

Reason: _____

Substance Abuse History:

Have you ever, or are you now being treated by any type of chemical dependency abuse? Yes No

If yes, when? _____ Where? _____

By whom? _____ Length of treatment: _____

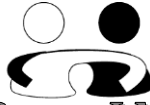
Are you using any type of chemical substance at this time? Yes No

If yes, please indicate what you are using: _____

How frequently do you use these substances? _____

Medical History:

Are you presently under a physicians care for physical problems? Yes No



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If yes, please list reasons and any medications:

Name of family physician: _____ Phone: _____

Current Reasons for seeking therapy:

What problems are you experiencing at this time?

What do you expect from therapy?

Please list everyone with whom you presently live:

What resources do you have (internal and external) that help you feel a bit better when you think about them? _____

(Signature)

Date: _____



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PRE-NATAL AND DEVELOPMENTAL HISTORY

Sometimes events occur during pregnancy and early development that can effect how we behave and think today. It can be helpful for your therapist to know if anything occurred during this time frame, in order to better assist you in healing. If you are willing, please complete the following information to the best of your ability, if you would like this aspect to also be reviewed. Otherwise, feel free to leave this section blank. Thank you!

Client's Developmental History:

Were developmental milestones met early, late, normal: _____

Was the client routinely followed by a pediatrician for first five years of life? _____

Child have any congenital defects requiring treatment e.g. heart defects, hydrocephalus, cleft lip/palate, etc.? _____

Child speech develop within normal time frames? _____

Child growth and development occur with normal time frames? _____

Child begin walking within normal time frames? _____

Child have any vision or hearing developmental difficulties? _____

Child begin school as scheduled, or was school delayed? _____

Child's early school years run a normal course, or did socialization/behavior problems exist?

Child have any diagnosed learning disabilities? _____

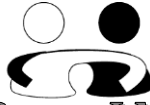
Child have diagnosed hyperactivity? _____

Child have history of needing Ritalin, asthma medications, or allergy medications?

Child exhibits tendencies to hurt other children or animals? _____

Pre-natal/Peri-natal History (medical problems during pregnancy, mother's use of medications, details of labor/delivery etc.): _____

Was the pregnancy a normal pregnancy, or were there problems such as toxemia, pregnancy induced diabetes, preeclampsia, placenta previa, etc.?



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Was the pregnancy full term, or was the delivery premature? _____

Did mother use drugs or alcohol during the pregnancy? _____

Is/was the mother addicted to drugs/alcohol and using during pregnancy? _____

Was the baby born addicted; requiring detox in the nursery? _____

Did the baby require time in an intensive neonatal nursery? _____

Was the birth weight considered normal, or were parents told it was too low or too high?

Client/Guardian signature

Therapist's signature with professional degree indicating review of document