Kelly Ferraro LPC, PLLC

Demographic Form

Name:_____ DOB:_____ Date:_____

Home Address:_____

Phone:_____ Email:_____

OK to be called, and leave a message? Yes/ No

Ok to receive contact by email? Yes/ No

Marital Status: S / M / D / W Date of current current marriage/separation:_____

Spouse's Name:_____ Were you previously married? Y / N, If yes, when?

How long?_____ Occupation:_____ Highest Level of Education:_____

Children's Name(s): _____ Age:_____ M / F

_____ Age:_____ M / F

_____ Age:_____ M / F

Medical History

Physician/Psychiatrist/Chiropractor:_____ Location:_____

Are you currently experiencing any physical problems?_____

Previous Hospitalizations for mental health? (date/reason/where):_____

_____

Medications:_____ Dosage:_____ For how long?_____

Have you had any previous counseling? If yes, for what reason? How long?_____

_____

Name and location of previous counselor:_____

Reasons for Seeking Help

What concerns have brought you to counseling:_____

_____

_____

When did your present concerns begin to be a problem for you?_____

_____

What do you hope to gain from counseling?_____

_____

How did you hear about me / who referred you?_____

Are you a member/regular attender of a church? Y / N

If yes, which church?_____

Emergency Contact

Name:_____ Relationship:_____

Address:_____

Phone:_____ Is this contact aware you are in counseling? Y / N