Dr. Judy Chamberlin LCSW, PsyD

Individual, couples and family counseling
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COUPLE/FAMILY INFORMATION FORM

Client Name: ____ Date of Birth: _______________

Partner Name: _______________________________________ Date of Birth: _______________

Address: ______________________________ City_______________ State: ______ Zip: _______

Partner Address if different from above: ____

Client Phone: ___________________________ Partner Phone: ___________________________

Client Email: ___________________________ Partner Email: _____________________________

Client Occupation: ______________________ Partner Occupation: _________________________

Relationship status (circle one) Married Life-Partner Engaged Separated Divorced Years Together___

Others living in your home:

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship _________

Name: ____ Age: _____ Relationship __________

Client info:
Previous Therapist: _______________________________ How long: From_______ to__________

Current Psychiatric Medication: ______________________ Prescribing Doctor _________________

Current Health Problems: ____

Partner info:
Previous Therapist: _______________________________ How long: From_______ to__________

Current Psychiatric Medication: ______________________ Prescribing Doctor _________________

Current Health Problems: ____

Who May I thank for referring you to this office:

_______________________________ _______________________________ __________
Name Address Phone

Other Referral Source: