

Family Restoration Counseling Services

8340 Meadow Rd. Suite 134, Dallas TX 75231

214-265-1777

www.familyrestorationcounseling.com

Client Information

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Telephone Number: _____

Email Address: _____

DISCLAIMER: Texting, like email, has inherent risk of being intercepted / read by parties other than those intended to receive it. By initialing "YES" below, you acknowledge this risk and authorize Family Restoration Counseling Services, PLLC to exchange text communication with you anyway.

Family Restoration Counseling may communicate with me via:

Email Communication: YES _____ NO _____ Texts: YES _____ NO _____

Home Address: _____ Apt No. _____

City: _____ State: _____ Zip: _____

Please list any medications you are on: _____

Family History:

Relative	Name	Age	Relevant Illness	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Sibling	_____	_____	_____	_____	_____
Sibling	_____	_____	_____	_____	_____
Sibling	_____	_____	_____	_____	_____

Relationship History (Married / Engaged/ Cohabiting):

Spouse's Name	Year Relationship Started	Year Relationship Ended	Ended due to:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children:

Name	Age	Gender	Concerns
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Counseling / Treatment History: Please describe any previous counseling you have had including the reason(s) you sought counseling, name of counselor and approximate dates of treatment).

Briefly describe your reason for coming in for counseling at this time.

Is there anything you think your therapist should know about you and your family from the start of counseling?

Signature: _____

Date: _____