

Erin P. Hwasta, MA, MFT
Marriage and Family Therapist MFC #46966

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CLIENT INFORMATION

Today's Date: _____

Client Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Mailing Address: _____

Home Phone: _____

Work Phone: _____ Mobile Phone: _____

May I use my name if I phone your work? ___ Yes ___ No

May I use my name if I phone your home? ___ Yes ___ No

Email Address: _____

Do you check email daily? ___ Yes ___ No

May I use email to communicate with you? ___ Yes ___ No

Occupation: _____

Employed by: _____

Marital Status:

___ Single ___ Married ___ Partnered ___ Divorced

___ Widowed ___ Separated

Length of relationship (if applicable) _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Describe any medical issues that may be of concern:

List any medications you are currently taking:

CLIENT INFORMATION

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What is the date of your last physical exam? _____

How many alcoholic drinks do you consume per day? _____

Do you use recreational and/or pharmaceutical drugs? ___ Yes ___ No

If so, please describe.

Have you had any previous therapy /counseling experiences? ___ Yes ___ No

If so, please describe type and length of therapy:

Please use this space for any additional information you feel is valuable for me to know.
Thank you.

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