Linda Piantieri, MA, NCC
Licensed Marriage & Family Therapist and Licensed Mental Health Counselor
Lee World Center, 1850 Lee Road, Suite 212, Winter Park, FL 32789
www.lindaPiantieri.com phone: 407-719-2525 email: linda@lindapiantieri.com

Date: ____________________________

Client Name: ____

Nickname or name client prefers to be called ____

Date of Birth: ______________________ Age: ___________ Gender: _____________________

Client Address: ________________________________ City: ________________ Zip Code: ____________

Email Address:____

Employer name and address____

City:____state:________zip code:_____________

Home Phone: (_____) ______________ Cell Phone: (_____)________________

Work Phone: (_____) _______________ Okay to contact at work? Yes / No

Name of Spouse or Significant Other ____

Nickname or name Significant Other prefers to be called____

Date of Birth: ______________________ Age: ___________ Gender: Male / Female

Significant Other's Address (if different than above): ____

City: ____State_________Zip Code: ____________

Significant Other's Employer name and address

____

City: ____State__________ Zip Code:___________

Home Phone: (_____)________________Cell Phone (________)_____________________________________

Work Phone: (______)__________________________Okay to contact at work? Yes / No

Email Address____

Referred by: ____

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Family and Home

Father living?___ Mother living?___Number of Sisters___ Ages____Number of brothers___Ages_______

Children and ages____

____

____

____

Occupation of father____

Occupation of mother____

Please list the members of your current household____

____

____

____

Health

Do you have normal eyesight?____

Do you have normal hearing?____

Have you had any surgeries?____

Briefly summarize important factors in your health history____

____

____

____

How much do you drink? daily____________weekly_____________monthly______________________

Have you felt the need to cut down on your drinking? __________________yes __________________no

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Do you feel annoyed by people complaining about your drinking? __________yes ______________no

Do you ever feel guilty about your drinking? __________yes ___________no

Do you ever drink an eye-opener in the morning to relieve the shakes? __________yes ___________no

Handicaps/Disabilities____

Current Medications and length of time on each____

____

____

____

Current physician/psychiatrist and phone number(s)____

____

Other Counseling or Therapy

Have you previously seen or are you currently seeing another counselor or therapist? If so, please list the name of the counselor/therapist, the name of the agency consulted (if applicable), the topics of concern for which assistance was requested, and the time period for which counseling was conducted.____

____

____

Briefly describe circumstances that prompted you to request counseling at this time. _________________

____

____

____

____

Please continue on the back side of this sheet with any/all information. Thank you.