Cornerstone Counseling and Education

Personal Information **Assigned Practitioner:**

First name	Middle initial	Last name	Today's date

Street address	City	State	Zip	Home phone

Email address	Cell phone	Social security number SS #	

Birth date	Sex: ☐ Male ☐ Female	Employer name	Business phone

List present or previous health problems

List any medications you are currently taking

Spouse or Parent Information if under 18

First name	Middle initial	Last name	Marriage date

Street address	City	State	Zip	Home phone	Business phone

Birth date	Sex ☐ Male ☐ Female	Social security number SS #

List present or previous health problems

List any medications you are currently taking

Children's Information

Instructions: List all children

Name	Age	Lives with you?	Name	Age	Lives with you?

Other Information (PLEASE COMPLETE THIS SECTION)

What do you hope to change or accomplish by seeking help at this time? (Use the back of the form if more room is needed.)

List any agencies or other professionals who have provided you counseling services in the past. (Use the back of the form if more room is needed.)

Signature	Signature

3/2009