JEFFREY D. RISSER, L.C.S.W.

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Name: _____ Date of Birth: _____
Significant Other's Name:_____ Date of Birth: _____
Address: _____ Male: _____ Female: _____
City/State/Zip: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Ok to leave a message? _____

If Minor, please list legal guardians/parents:
Name: _____ Telephone: _____
Name: _____ Telephone: _____

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Children/Ages: _____

Siblings/Ages: _____

Occupation: _____ Education: _____

Referred by: _____ Previous Counseling: _____
Emergency Contact (Name & #): _____
Current Medications: _____
Primary Care Physician: _____ Phone: _____
Alcohol Use (frequency/amount): _____
Drug Use (frequency/amount): _____

Reason for seeking counseling at this time:

_____

_____

What would you like to accomplish from your time in counseling?

_____

_____

Spiritual or Religious Affiliation: _____

What are your strengths? _____

Challenges? _____

Do you exercise regularly (how often?): _____

How would you rate your sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent

How would you rate your eating habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Excellent