MORNINGSIDE
THERAPY

Date: _____

Client Information

Name(s):
Home Address:
Preferred Phone Number: Alternative Phone Number:
Email Address:
Date of Birth:
Occupation(s):
Marital Status (please circle): Never Married Married Remarried Partnered Divorced Separated Widowed
Medical/Mental Health Diagnosis? Yes No If yes, please list the name of the family member and the diagnosis: Is anyone currently taking medication? Yes No If yes, who? Name of all medications taken: Name of prescribing physician:

Name of Psychiatrist, if Applicable:
Emergency Contact Name: Emergency Contact Phone Number: Emergency Contact Address:

Therapy Participants

Name	Relationship	Date of Birth	Where living?

Briefly state why you are here: