Information entered into this form is not saved. Please print the completed form and bring to the first session.

Clear
Return
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# Judith Velez Ph.D. LCSW

**Name:** _____ **Date of Birth:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

**Occupation:** _____ **Social Security Number:** _____

**Home Phone # (Include area code)** _____ **Work Phone # (Include area code)** _____

**Cell Phone # (Include area code)** _____ **Emergency Contact # (Include area code)** _____

**Please list the members of your household:**

| Name | Date of Birth | Occupation or School |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Health Information (Please include any hospitalizations, medical problems; past and present):**

**Please list any prescription medications:**

**Please list any current or past drug use (please include any admissions to any drug treatment facilities):**

**What is your current alcohol consumption?**

**How can I help you? What has made you seek counseling/psychotherapy at this time?**

**Confidentiality Policy**

**All discussions between client(s) and therapist remain confidential except in the following instances:**

1. **Possibility of harm to self or other**
2. **Court order**
3. **If your managed care company requests periodic summaries of the treatment in order to certify additional sessions**