

# Steere Family Therapy

8013 Brownsboro Road

Louisville, KY 40241

502/295-5008

Fax: 502/267-4472

*Louisvillefamilytherapy.com*

## CLIENT INFORMATION AND CONSENT FORM

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

\_\_\_\_\_ Email address: \_\_\_\_\_

Please describe the issues that have brought you in today. \_\_\_\_\_

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Please list any current or previous medical issues, treatments and outcomes of all family members you feel relevant to these issues.

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Please list any current or previous psychiatric/psychological issues, treatments and outcomes of all family members.

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Please list any current or previous diagnoses of all family members. \_\_\_\_\_

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Please list any current or previous psychotropic medications of all family members. \_\_\_\_\_

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Please list the current and past use of drugs or alcohol including frequency & substance use of all family members (include any treatment if applicable).

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Please describe your family history as it pertains to mental illness (including diagnoses), chemical dependency, suicide, major medical problems and traumas. \_\_\_\_\_

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Please describe how these past and current issues are currently affecting you and your family. \_\_\_\_\_

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Please list client strengths & support systems. \_\_\_\_\_

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**Signature provides consent for Steere Family Therapy to provide services to the identified individual, couple and/or family. Information shared with Steere Family Therapy will be kept confidential unless it contains information relating to a serious threat of death or harm to a named individual or suicide ideation, physical or sexual abuse which will be reported to authorities as required by law.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_