Dr. Burt Bertram (Ed.D.)

Licensed Marriage & Family Therapist

Licensed Mental Health Counselor

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**Client Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Referred by: |       | Date: |       |

**CLIENT #1**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Email |       |
| Address: |       | City, State |      ,     | Zip |       |
| Education: |       | Occupation |       | Employer |       |
| Phone (C) |       | Phone (W) |       | Phone (Other) |       |
| Birth Date |       | Age |    | Marital Status |       | Years Partnered |      |
| Previous Marriages |    | Religious Preference |       | Active? |     |

**CLIENT #2**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Email |       |
| Address: |       | City, State |      ,     | Zip |       |
| Education: |       | Occupation |       | Employer |       |
| Phone (C) |       | Phone (W) |       | Phone (Other) |       |
| Birth Date |       | Age |    | Marital Status |       | Years Partnered |      |
| Previous Marriages |    | Religious Preference |       | Active? |     |

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**Immediate Family Living at Home** (Other than those listed above)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | **Birth Date** |  | **Age** |  | **Relationship** |
|       |  |       |  |    |  |       |
|       |  |       |  |    |  |       |
|       |  |       |  |    |  |       |
|       |  |       |  |    |  |       |

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|  |
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| **What is the problem that brought you to counseling?**  |
|      |
| **Previous Counseling/Psychotherapy (With Whom and When)** |
|       |
| **Medical and Health Information:** |
| Please describe your general health including any specific health conditions that may have a bearing on your emotional well-being. |
|  |
| **Client #1:** (Describe)      |
| Personal/Family Physicians |       | Phone |       |
| Specialist/Other Physicians |       | Phone |       |
|  |  |  |  |
|

|  |  |  |
| --- | --- | --- |
| Current Medications |  | Prescribed by |
|       |  |       |
|       |  |       |
|       |  |       |
|       |  |       |

 |
| **Client #2:** (Describe)      |
| Personal/Family Physicians |       | Phone |       |
| Specialist/Other Physicians |       | Phone |       |
|  |
|

|  |  |  |
| --- | --- | --- |
| Current Medications |  | Prescribed by |
|       |  |       |
|       |  |       |
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|       |  |       |

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**Person Responsible for Payment:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |       | Email |       |
| Address: |       | City, State |      ,     | Zip |       |
| Phone (H) |       | Phone (W) |       | Phone (C) |       |