Dr. Burt Bertram (Ed.D.)

Licensed Marriage and 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? | | | |  |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** |  | **Birth Date** |  | **Age** |  | **Relationship** |
|  |  |  |  |  |  |  |
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|  |
| --- |
| **What is the problem that brought you to counseling?** |
|  |

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|  |  |  |  |
| --- | --- | --- | --- |
| **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 | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | |

**Person Responsible for Payment:**

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