The Bridge
CENTER FOR PLAY THERAPY

Adult Information

Name _____ Male_____ Female_____Age _____ DOB _____
Address _____City_____ State_____ Zip_____
Phone_____Email_____
Occupation_____ Highest Level of Education_____
Relationship Status □ Single □ Living Together □ Married □ Widowed □ Separated □ Divorced

Medical Information

List all illnesses/accidents/injuries:

Illness/Accident/Injury_____ Date_____ Treatment_____
Illness/Accident/Injury_____ Date_____ Treatment_____
Medication being taken_____ For_____ Physician/Medical Provider_____
Medication being taken_____ For_____ Physician/Medical Provider_____

Describe type and quantity of alcohol you drink per week_____
Describe type and quantity of Marijuana you use per week_____
Indicate any other recreational drugs you use_____
Has anyone complained about your alcohol or drug use? □ Yes □ No

Mental Health Information
Please check any past or present concerns:
□ Depression □ Self-Esteem □ Trauma □ Parenting Differences □ Depression □ Health Problems □ Grief/ Loss
□ Sexual Abuse □ Alcohol/Drugs □ Sexuality □ Job Related problems □ Legal Problems □ Child Rearing
□ Domestic Violence □ Communication □ Anxiety □ Financial Concerns □ Marital Problems □ Death of a loved one
□ Compulsive behaviors □ Sleep Problems □ Injury/ Illness □ Suicidal Thoughts □Aggression □ Relationship issues
□ Separation or Divorce □ Other

Please describe any current struggles and concerns
_____
_____

Are you currently in counseling elsewhere? □ Yes □ No
Have you had previous counseling? □ Yes □ No

What is most important and matters most to you?
_____
_____

Describe you personal goals for the counseling process
_____
_____