Shenandoah Valley Counseling Center, LLC

Maggie Campbell, LCSW
Therapist
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SOCIAL / PERSONAL / HISTORY:

Please complete the following sections of this form. This information will be required prior to the initial session to assist the therapist in providing clear, concise, and effective assistance.

Contact Information:

(Child- only)

NAME:_____Parent /Legal Guardian: _____

Address:_____ Date of Birth: _____

Contact information:

Phone: _____ Email: _____

Marital Status: _____ Spouse or Significant Other:_____

Children or other dependents: _____

Emergency Contact: _____Relationship:_____

Reason for your Visit: Concern / Complaint: _____

_____

Medical Information:

Mental Health Diagnoses: _____

Psychiatrist or Prescribing Physician: _____

Medication(s) Prescribed and Dosage amount: _____

Previous Counselor / Therapist: _____

Medical Diagnosis: _____

Physician:_____

Medication(s) Prescribed and Dosage amount:_____

Insurance(s): _____

Employment /Social/ Interests:

Employment: _____

Interests or hobbies:_____

Support System/Family members, friends, etc: _____

Spiritual / Religious: _____

Areas of stress --home/ relationship/employment:_____

Thank you for providing detailed information in completing this form. Please bring the completed form with you to the first appointment with the therapist.