

Family Composition

Name _____	age _____	relation _____
Name _____	age _____	relation _____
Name _____	age _____	relation _____
Name _____	age _____	relation _____
Name _____	age _____	relation _____

Relationship/Marriage History _____

Employment _____

Education _____

School Contact person: _____

Counseling/Psychiatric History _____

Current Medication _____

Doctor/Psychiatrist _____

Consent to share information signed? _____

How did you find out about Building Blocks Counseling Services? _____

Other Symptoms _____

(OFFICE USE)

Treatment Goals

1. _____
2. _____
3. _____
4. _____
5. _____

Diagnosis

Clinician Wendy Woolf, MA LMHC