

Nurturing Life Concepts. LLC
Wendy A. West Pidkaminy, LCSW-R
Executive Officer
8195 Cazenovia Road, Suite 9
Manlius, NY 13104
(315) 682-4005
www.nurturinglifeconcepts.com

Couples Demographic Form: Each Spouse, Please Fill Out Your Own Form

Today's Date:		
Name (First, Middle Initial and Last)		
Social Security Number	DOB	Age
Residential Address:		
Home Phone:	Cell Phone:	Work Phone:
Email address:		
<p>May we email, text and or leave messages? NLC will never include any personal or clinical information in such messages, unless the correspondence was initiated, authorized or requested to do so by you. NLC may contact you about missed or rescheduled appointments. Anyone who reads such information or listens to telephone messages would realize that you have come to see NLC for services. Also note that text and email correspondence is vulnerable to interception and is not considered reliably confidential. Know that you are sending info in this manner at your own risk.</p>		
You may email me at the following email address:		
You may text and or call the following phone number:		
Gender: M F T		
Education Level:		
Marital Status: Married Separated Remarried Divorced Widowed In a relationship other		

Immediate Family Relationships/Family Constellation (spouse, children, siblings, parents etc) List each person <u>Name:</u> _____ <u>Relationship</u> _____ <u>Age</u> _____ <u>Location</u> (ie live with you etc)	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Currently Employed or attending school: Y N Employer/School: _____	
Position Held: _____	Length of Time: _____
_____	_____
Work Address: _____	Work Phone: _____

Current Allergies: Y N If yes, please describe in detail: _____

Have you ever been in the military or are you currently enlisted in any branch of the US military? Y N

If you answered yes to the above question, did your military experience include any traumatic or highly stressful experiences which continue to bother you: Y N If yes please list: _____

Have you ever been convicted of a crime or had legal difficulties? Y N If yes, please describe in detail: _____

Have you ever been identified with a documented disability, including: ADHD____; Deaf or hard of hearing____; visual impairments____; learning disorders____; mobility impairments____; physical/health related disorders____; neurological disorders____; psychological disorders____; Other (please specify):_____ If you checked yes on the above please provide detailed information:

Medical History: (include current medications (prescribed, OTC, and supplements), hospitalizations, medical diagnoses/procedures, allergies, smoking history, caffeine intake, alcohol and drug use/abuse and exercise habits:

Significant Psychiatric History/Current Treatment Y N If YES, please explain

History of suicide attempts, cutting or self mutilation, addictions, disorders? Y N If yes, please explain:

Family History: (history of trauma or violence, psychological/medical concerns in family members, social supports, etc...

What are your personal skills, strengths and abilities:

Do you have a support system? If yes, please describe:

What Goals do you wish to accomplish in counseling?-

Please list anything that was not asked that you feel is pertinent here:
