Kathleen Litchfield, MFT
29 Howe Ave. Shrewsbury, MA 01545

Client Personal Information/History

Name_____

Age_____DOB_____

Address_____

_____

Phone_____cell_____work_____

_____

Email_____Permission to send brief texts?_____

Yes_____ No

Place of

Employment_____

__

Occupation_____ How

Long_____

Marital Status_____ Spouse's

Name_____

If Married 1st, 2nd etc_____ How

Long?_____

Children: Names &

Ages_____

Number of Siblings_____ Are your parents living_____deceased _____

when?_____

Who lives in your

home?_____

Do you have any medical issues?

Describe_____

Do you have any history of substance abuse?

_____

Describe_____

_____

Do you have now, or have ever had a mental health diagnoses? _____

Describe

_____

___

Any family members with history of substance abuse or a mental health diagnosis?_____

Describe

_____

___

Your cultural heritage

_____

Do you have any religious affiliation or spiritual

beliefs?_____

Have you ever been in therapy before?_____

When?_____

Briefly tell of your reason for seeking

therapy_____

_____

_____

_____

Thank you for filling out this form!