HEALING STEPS FAMILY THERAPY, LLC

Stephen M. Stepanovich, MS, LMFT

Date: _____

Name of Client	**Home Phone**	**Business Phone**	**Date of Birth**	**Age**

Street Address	**City**	**State**	**Zip Code**

Social Security Number	**Occupation**	**Education/Degree**	**Gender**

Place of Employment	**Nearest Relative**	**In case of emergency, notify (name):** **Phone:**

Marital Status: **__Never Married** **__Married** **__Living w/ Partner** **__Divorced** **__Widowed** **__Separated** **If married, how long? _____**	**Referral Source-Agency or Individual**	**Other Agencies Involved**	
	Primary Care Physician	**Religion**	
	Name of School (if attending)	**Grade**	**___Special Educ.** **___Gifted Educ.** **___504 Plan** **___ESL**

Family Members (Spouse/partner, children)

Name	**Age/DOB**	**Relationship**	**Grade/Occupation**	**Living in Home** **Yes**	**No**

Client's Family of Origin (Mother, father, brothers, sisters)

Name	**Age**	**Relationship**	**Grade/Occupation**	**Living in Home** **Yes**	**No**

Medications - Please list current medications of the <u>person for whom you are requesting therapy</u> (child, teen, adult)

Previous Therapy Treatment (With whom? How long?)