Lillian Solis-Smith, PHD, LPC, LMFT

Thank you for choosing Dr. Lillian Solis-Smith. By answering the questions below as completely as you can, you will help us to understand you and your situation more fully. **ALL INFORMATION IS CONFIDENTIAL**.

First MI Last Client Name	Gender: Male ☐ Female ☐	Today's Date: ___/___/___
Home Address	Home Phone # ( ) Cell # ( )	
City State Zip	Date of Birth	Age
Employer	Occupation	
Business Address	Business Phone # ( )	
City State Zip	Social Security #	
Relational status: ☐Single ☐Married ☐Committed Relationship ☐Separated ☐Divorced ☐Widowed		
Number of persons other than yourself living in your household?	Adults: _____ Children: _____	

Name of Responsible Person / Parent / Legal Guardian First MI Last	Date of Birth	Age
Employer	Occupation	
Business Address	Business Phone # ( )	
City State Zip	Social Security #	

Children's Names	Sex	Age	Descriptive Comment

Have you experienced any major changes or events in your life during the past year? Y ☐ N ☐
Have you experienced the loss of a friend, family member or other significant person during the past year? Y ☐ N ☐
Are you presently seeing another counselor? Y ☐ N ☐ If yes, whom?
Have you had previous counseling or psychotherapy? Y ☐ N ☐ Where?
Why are you presently seeking counseling?

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Physician:	Phone #

Are there any health conditions your counselor should be aware of? Y ☐ N ☐ If yes, please describe.

Do you or anyone in your family consume alcohol or other drugs for any reason other than medical necessity?

If so what? How often? How much?

Are you currently taking any medications? Y ☐ N ☐ If yes, please list and give the reason.

Does anyone in your family experience rage?

ACKNOWLEDGMENT OF REFERRAL

It is the practice of Dr. Lillian Solis-Smith to acknowledge and thank members of the professional community for their trust in referring persons to us. Your signature below gives us permission to make such contact by phone or letter.

Name of Referring Individual:_____

Street Address:_____ City _____ Zip _____

Your Signature:_____

CANCELLATION AND RETURNED CHECK POLICIES

Because counseling hours are reserved, Dr.Solis-Smith charges for sessions canceled when less than 24 hours notice is given.

There will be a $25 charge for each returned check or “do not honor” credit card payment.

I have read and understand these policies.

Signed:_____

Date:_____