PAUL FLORES, MSW LCSW

Psychotherapy, Clinical Supervision and Consultation Services

Date: _____

Name: _____ DOB:_____

Address: _____
_____NC, Zip: _____

Home Telephone: (____) _____ Work Telephone: (___) _____

Cellular Telephone: (___) _____ Email: _____
Employer:_____
School/ Grade: _____
*(For under age 18): Mother's name and cell #: _____
Father name and cell #: _____

Spouse: _____ Age: _____
Spouse's employer:_____ Years married:_____

Previous
marriages:_____

Children/ ages:
_____
Siblings (for client under 18) :
_____
Medical problems/Primary care MD/
medications:_____
_____
Past counseling, (where/when):
_____
_____
Reason for today's appointment:
_____
_____
Any important additional information:

Draw diagram of family and significant connections. Example—>