PATHWAYS COUNSELING CENTER, INC.

Brief description of why you would like to be seen today:

Household members other than yourself:

Name: ______________________________

Relationship ______________________________

Date of Birth (IF CHILD) ______________________________

Date of marriage or living together______________________________

Name: ______________________________

Relationship ______________________________

Date of Birth (IF CHILD) ______________________________

Date of marriage or living together ______________________________

Name: ______________________________

Relationship ______________________________

Date of Birth (IF CHILD) ______________________________

Date of marriage or living together______________________________

Name: ______________________________

Relationship ______________________________

Date of Birth (IF CHILD) ______________________________

Date of marriage or living together______________________________

Name: ______________________________

Relationship ______________________________

Date of Birth (IF CHILD) ______________________________

Date of marriage or living together______________________________

Name: ______________________________

Relationship ______________________________

Date of Birth (IF CHILD)______________________________

Date of marriage or living together______________________________

COMPLETE OTHER SIDE

Current list of medications (including over-the-counter medications):

Past Outpatient mental health or alcohol/drug treatment:

Place: ______________________________

Dates: ______________________________

Place: ______________________________

Dates: ______________________________

Place: ______________________________

Dates: ______________________________

Past Psychiatric Hospitalizations:

Place: ______________________________

Dates: ______________________________

Place: ______________________________

Dates: ______________________________

COMPLETE OTHER SIDE