Jennifer L. Streit, LMHC
APPLICATION FOR COUNSELING

Today's Date:_____

NAME: _____

Date of Birth: _____ Social Security:_____

ADDRESS:_____
TELEPHONE:
Home:_____Cell:_____Work:_____

Email Address:_____
EMPLOYER:_____

EMERGENCY CONTACT
Name: _____ Relationship: _____
Phone: _____

EDUCATION: _____

DO YOU HAVE ANY COMMUNICABLE DISEASES (E.G. HEPATITIS C, AIDS, TB)?_____

WHAT MEDICATIONS ARE YOU TAKING?_____

WHO IS PRESCRIBING YOUR MEDICATION?_____

REASON FOR SEEKING COUNSELING: _____
_____
_____

How long have you been dealing with these issues? _____
_____
Have you ever been in counseling before? _____
If so, how as it helpful? _____
_____
_____
Have you ever had a suicide attempt/thoughts? If yes, please explain_____
_____

Have you ever been hospitalized for psychiatric reasons? If yes, when and where_____
_____

Fee: $100.00 per session, to be paid each session