



# AVENUES UNLIMITED COUNSELING CENTER, INC

NAME: \_\_\_\_\_ GENDER: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ EXT: \_\_\_\_\_

MOBILE PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

EMAIL: \_\_\_\_\_ @ \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

IN CASE OF EMERGENCY PLEASE NOTIFY: \_\_\_\_\_

HOW DID YOU LEARN ABOUT AVENUES: \_\_\_\_\_

## EMPLOYMENT

OCCUPATION: \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ PLACE OF EMPLOYMENT \_\_\_\_\_

## EDUCATION

SELF: \_\_\_\_\_

SPOUSE: \_\_\_\_\_

## CHILDREN:

NAME(S): \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICAL

NAME/ADDRESS OF INTERNIST OR GENERAL PRACTITIONER: \_\_\_\_\_

NAME/ADDRESS OF PSYCHIATRIST \_\_\_\_\_

PREVIOUS PSYCHOTHERAPIST(S) \_\_\_\_\_

ILLNESS REQUIRING MEDICAL OR HOSPITAL TREATMENT IN LAST 12 MONTHS: \_\_\_\_\_

CURRENT MEDICATION(S) \_\_\_\_\_

\_\_\_\_\_

**ESTIMATE YOUR DAILY USE**

ALCOHOL \_\_\_\_\_ CAFFEINE \_\_\_\_\_ TOBACCO \_\_\_\_\_

**CURRENT/PRIMARY ISSUES FOR WHICH YOU WISH PSYCHOTHERAPY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**RELEASE OF INFORMATION**

I hereby request that \_\_\_\_\_  
at (address) \_\_\_\_\_ furnish Eric W Baker, the  
following information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby grant Mr. Eric W. Baker, LCSW to provide the following information

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

to: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I have been informed of the limits of confidentiality \_\_\_\_\_ initial