YOUR THERAPY
HOUSTON
REDEFINING YOURSELF AND YOUR RELATIONSHIPS

Name: _____ Date: _____

Date of Birth: _____

Contact Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Other: _____Email: _____

Employment/School Information

Employer: _____

Position: _____ Work Phone: _____

School: _____Grade Level: _____

Highest grade completed: _____

Emergency Contact(s)

Name: _____

Relationship: _____ Phone Number: _____

Name: _____

Relationship: _____ Phone Number: _____

_____: I give permission for my emergency contacts to be reached when fit necessary

Signature: _____

5900 Memorial Dr., Suite 218
Houston, TX 77007
832-475-3904
info@yourtherapyhouston.com

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Medical Information

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

When was your last visit to your doctor? _____

_____: I give permission for my PCP to be reached when fit necessary

Signature: _____

Referral Source

Name of who referred you: _____

May they be contacted for a thank you?

_____: Yes, my permission is given

_____: Yes, but do not disclose my name

_____: No

Signature: _____

Counseling Interest

____: Individual Therapy ____: Couples Therapy ____: Family Therapy ____: Group Therapy

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