

Sallie Lowman, LMFT
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Background Information

Date _____

Name _____ Age _____

Address _____ City/State _____ Zip: _____

Contact
 Home phone _____ Work phone _____ Cell _____

Email _____ Which contact method preferred? _____

Emergency Contact Name/Number _____

Vocational Information

Employer _____ Job Title: _____

Educational Information

Highest grade/degree achieved in school: _____

Medical Information

Current medical problems: _____

Current Physician: _____

Current Medications: _____

Family Information

Spouse's name and Date of marriage	Age when married	Length of marriage	Reason For termination	Children		
				Names	Ages	School
1 st						
2 nd						
3 rd						

Name of Spouse: _____ Age: _____

Address: _____ Phone: _____

Spouse's highest level of education: _____ Employment: _____

Therapy Purposes

Briefly state the issue(s) which brought you here: _____

Prior experience with counseling: _____

What are your expectations for counseling? _____

Is there any other information you'd like me to know? _____
