LOUIS LAVES-WEBB
LCSW, LPC & ASSOCIATES
PSYCHOTHERAPY FOR ADULTS, ADOLESCENTS, AND COUPLES

www.LouisLaves-Webb.com
(512) 914-6635

Patrick Turbiville, LCSW
Supervised by Louis Laves-Webb, LCSW, LPC-S

CONFIDENTIAL CLIENT INFORMATION

Date _______________

Name ____ Social Security # _________-_______-________

Preferred Name/Nickname ____________________________

Address ____

City / State / Zip ____

Home/Mobile Phone ________________________ OK to leave a message? ☐Yes ☐No

Work Phone ________________________________ OK to leave a message? ☐Yes ☐No

Email _____________________________________ OK to send email? ☐Yes ☐No

Would you like reminders about your sessions? ☐Email ☐Text ☐Voice ☐No Reminders

Occupation ________________________________ Employer ____

Sex/Gender ________________________________ Race & Ethnicity ____________________________________

Date of Birth _______________ Age ______ Relationship/Marital Status ____________________________

Insurance Company ________________________________ Group/Policy Number _________________________

Name of physician ____

Name(s) of previous therapist(s) Dates seen

____ ________________________

____ ________________________

____ ________________________

Describe any health concerns: ____

List drugs/medications you presently use:

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Referred by: ________________________________ Phone: ___________________________

Please describe briefly the concern(s) that bring you here:

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Please check any of the following items which concern you:

- ☐ Self-esteem, self-confidence
- ☐ Anxiety, nervousness, fears
- ☐ Depression
- ☐ Sexual concerns
- ☐ Angry, hostile feelings
- ☐ Traumatic experience
- ☐ Physical distress
- ☐ Eating or appetite problems
- ☐ Alcohol or drug problems
- ☐ Sleep problems
- ☐ Parent-child problems
- ☐ Family conflicts or pressures
- ☐ Friendship conflicts
- ☐ Relationship/marital concerns
- ☐ Shyness, being assertive
- ☐ Loneliness
- ☐ Procrastination or motivation
- ☐ Gay/Lesbian issues
- ☐ Suicidal feelings or behaviors
- ☐ Stress
- ☐ Self-control
- ☐ Health problems
- ☐ Work or career concerns
- ☐ Other: ______________________________

Please *circle the checkbox* next to those items that are of *particular* concern to you right now, like this: ☑

Please list the members of your immediate family (include parents, siblings, spouse/partner, children, and all others in your home):

Name	Relationship	Age	Occupation	Education