Ascendance Therapy
Mandy Snider, M.Ed., AMFT

Patient Information
Adult

Patient Name: _____

Address: _____

_____

Phone: (___)_____ (___)_____ (___)_____
Home Work Cell

Sex: ___Male ___Female

Date of Birth: _____ Social Security Number: _____

Occupation: _____

Educational Level: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed

Name of spouse/significant other: _____

Emergency contact: _____ Relationship to you: _____

Phone: (___)_____

Presenting Concerns: (check all that apply)

- ☐ Abuse
- ☐ Addiction
- ☐ Alzheimer's
- ☐ Anger
- ☐ Anxiety
- ☐ Career counseling
- ☐ Chronic pain
- ☐ Coping skills
- ☐ Depression
- ☐ Divorce
- ☐ Eating disorder
- ☐ Family functioning
- ☐ Grief
- ☐ Infertility
- ☐ Infidelity
- ☐ LGBTQ
- ☐ Life coaching
- ☐ Marital issues
- ☐ Other:
  _____
  _____

Medical History

Significant illnesses, physical conditions, hospitalizations (include dates):

_____

_____

_____

_____

Medications currently using: _____

Name of doctor/clinic: _____

Phone: (___)_____

Referral Information

By whom were you referred: _____