Burt Bertram, Ed.D.

Licensed Marriage and Family Therapist (0145)
Licensed Mental Health Counselor (0863)

1059 Edgewater Dr. Orlando, FL 32804
Ph: 407-399-2344 (Cell)
Email burt@burtbertram.com

Individual Client Information & History

Name: _____ Date: _____

Address: _____ Referred by: _____

City: _____ State: _____ Zip: _____

Please indicate your preferred contact phone or email to reach you and leave a message.

Phone: Cell: _____ Home: _____ Office: _____

Email: _____ May we text your cell phone? Y☐/ N☐

Gender: _____ Age: _____ Date of Birth: _____ Race/Ethnicity:_____

Education: _____ Occupation: _____

Family Information

Spouse/Partner: _____

Children: Name Age

_____

_____

_____

_____

Marital Status

Married	_____ years
Domestic Partner	_____ years
Separated	_____ years
Divorced	_____ years
Widowed	_____ years
Single/Never Married	_____
Previous Marriages	_____

Briefly describe the problems/difficulties you are experiencing that brought you to counseling:

_____

_____

_____

_____

What is your Primary Goal for counseling? _____

_____

_____

Please describe any major changes in your personal or work life in the past year. _____

_____

_____

Previous counseling/psychotherapy (With whom and when)?

_____

_____

_____

Has there been any significant emotional traumas in your life, past or present?
Yes _____ No _____ If Yes - briefly describe _____

_____

_____

Are you now, or have you in the past, taken medication for depression, anxiety or any other condition related to your mental or emotional wellbeing? Yes _____ No _____

If Yes, please list medications and name of prescribing physician.

_____ _____

_____ _____

_____ _____

Is there a faith/religion/spiritual tradition that is important to you? Yes _____ No _____

If Yes, please identify this tradition _____

_____

Health Information - Please describe your general health including any specific health conditions that may have a bearing on your emotional wellbeing.

_____

_____

_____

Primary Care Physician: _____ Phone _____

What else? What other stressors (emotional, health, financial, legal, employment, losses/deaths etc.) are affecting your current state of mind that your counselor should know?

_____

_____

_____

Payment for Services: Who is responsible for payment?

_____ Client Self

_____ Other: Please provide contact information for the other

Name: _____

Address _____

Phone(s) _____

Email _____

Payment is appreciated at the end of each counseling session and can be made by check, credit card or cash.