Nicole Piland, PhD, LMFT
Licensed Marriage and Family Therapist
7021 Kewanee Ave., Bldg. 2-104
Lubbock, TX 79424
281-989-8640

CONTACT INFORMATION

Your Name: **Phone:** **Email:**	**Street Address:** **City:** **State:** **Zip:**	**Employer (if applicable):** **Job Title:**
Partner/Family Member (1): **Phone:** **Email:**	**Street Address (if not same):** **City:** **State:** **Zip:**	**Employer (if applicable):** **Job Title:**
Partner/Family Member (2): **Phone:** **Email:**	**Street Address (if not same):** **City:** **State:** **Zip:**	**Employer (if applicable):** **Job Title:**
Partner/Family Member (3): **Phone:** **Email:**	**Street Address (if not same):** **City:** **State:** **Zip:**	**Employer (if applicable):** **Job Title:**
Partner/Family Member (4): **Phone:** **Email:**	**Street Address (if not same):** **City:** **State:** **Zip:**	**Employer (if applicable):** **Job Title:**

PLEASE LIST ALL PERSONS IN YOUR HOUSEHOLD:

YOUR HOUSEHOLD	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**
Name					
Age					

IF YOUR CHILD LIVES IN TWO DIFFERENT HOUSEHOLDS, PLEASE INCLUDE AS MUCH INFO AS YOU CAN:

OTHER CAREGIVER HOUSEHOLD*	**Person 1**	**Person 2**	**Person 3**	**Person 4**	**Person 5**
Name					
Age					

*If applicable**

HEALTH/MEDICAL INFORMATION:

Are **YOU** currently being treated for any medical conditions?	**Yes/No**
If yes, please describe:	
Primary Care Provider Name:	**Phone #**
Psychiatrist Name (if applicable)**:**	**Phone #**
List medications **you** are currently taking (and for what condition(s))**:**	
Is **YOUR CHILD** currently being treated for any medical conditions?	**Yes/No**
If yes, please describe:	
Primary Care Provider Name:	**Phone #**
Medications **your child** is taking (and for what condition(s)):	
Is **YOUR PARTNER** currently being treated for any medical conditions?	**Yes/No**
If yes, please describe:	
Primary Care Provider or Psychiatrist's Name:	**Phone #**
Medications **your partner** is taking (and for what condition(s)):	

PLEASE IDENTIFY ANY AND ALL AREAS OF CONCERN THAT APPLY BELOW:

PERSONAL concerns	RELATIONAL concerns	FAMILY concerns
depression/suicidality	chronic health/terminal illness	child-adolescent problems
anxiety/stress	educational/career/ Employment transition	Attention-deficit/Hyper-activity (ADHD)
anger/irritability/mood swings	relationship break-up separation/divorce	Autism spectrum (ASD)
self-esteem/confidence	legal/financial	Down syndrome (Ds)
substance use problem or other addictive behaviors	intimacy/sexual problems	separation anxiety
disordered eating: restricting/avoiding binging/purging	mistrust and infidelity	obsessive-compulsive tendencies
self-harm/self-injury/cutting	Reproductive Health: pregnancy infertility adoption/surrogacy	other Intellectual Developmental Disability
gender identity and sexual orientation (self)	gender identity and sexual orientation (re: partner)	gender identity and sexual orientation (re: child)
spirituality/faith	Sexual coercion, aggression, or violence	VICTIM of: crime/assault
anticipatory grief or ambiguous loss	communication and problem-solving	CHILDHOOD ABUSE: physical/sexual/ emotional
OTHER PERSONAL CONCERNS:	OTHER RELATIONAL CONCERNS:	OTHER FAMILY/CHILD CONCERNS:
Bereavement	Date of death/loss:	Relation to you: