RANDOLPH C. MOREDOCK, PHD, LCMFT

4105 WEST 6TH ST., SUITE B-7

LAWRENCE, KS 66049

Date: _____

Name: _____ DOB: _____

Spouse/Partner Name: _____ DOB: _____

Address: _____

Phones: Home: _____ Cell: _____

Email: _____

Preferred method of communication: ☐ Home ☐ Cell ☐ Email

Relationship Status (Check all that apply)	Employment	Income Source(s)
☐ Married	☐ Full-time	☐ From employment
☐ Separated	☐ Part-time	☐ Disability
☐ Divorced	☐ Stay-at-home parent	☐ Unemployment
☐ Dating	☐ Unemployed	☐ TANF/Food Stamps
☐ Living Together	☐ Student	☐ Pension
☐ Living Apart	☐ Retired	☐ Other: _____

Length of time in current relationship: Together: _____ Cohabiting: _____ Married: _____ Separated: _____

(if applicable)

Children (including biological, adopted, step, or foster):

Name	Gender	Age	Type Custody?	
_____	☐ F ☐ M	_____	_____	☐ Yes ☐ No
_____	☐ F ☐ M	_____	_____	☐ Yes ☐ No
_____	☐ F ☐ M	_____	_____	☐ Yes ☐ No
_____	☐ F ☐ M	_____	_____	☐ Yes ☐ No

Please check any of the reasons why you are seeking therapy services:

□ Depression or anxiety □ Alcohol/Drug Use □ Difficulty w/ loss or death
□ Communication Difficulties□ Child/Parent Conflict □ Divorce Counseling
□ Thinking of harming self/others □ Abuse (physical/verbal) □ Child illness/death
□ Intimacy/sexual Difficulties □ Affair □ Financial conflicts
□ Other marital problems (please describe) or other information you would like to share:

_____
_____
_____

As you think about the primary reason that brings you here, how would you rate your level of concern and its frequency at this point in time?

Concern
- □ No concern
- □ Little concern
- □ Moderate concern
- □ Serious concern
- □ Very serious concern

Frequency
- □ No occurrence
- □ Occurs rarely
- □ Occurs sometimes
- □ Occurs frequently
- □ Occurs nearly always

What do you hope to accomplish through therapy?

_____
_____
_____

What have you already done to attempt to deal with your difficulties?

_____
_____
_____

What are your biggest strengths as a couple?

_____
_____
_____

Have you received prior counseling related to any of the above issues? □ Yes □ No
If yes: By whom:_____When: _____
Where:_____ Length of treatment:_____
Problems treated: _____
Outcome: □ Very successful □ Somewhat successful □ No change
□ Somewhat worse □ Much worse

Were you referred to this practice? □ Yes □ No If yes, by whom_____

Print Name: _____ Signature:_____

Date: _____