**ANN C. BLISS, M.A., LCMHC**
**LICENSED CLINICAL MENTAL HEALTH COUNSELOR**

**426 State St. Portsmouth, NH, 03801* 603-431-1191**

**CLIENT INFORMATION**

**Date__/__/___**

**NAME:__________________________________ Date of birth __/___/____ AGE________**

**HOME ADDRESS:______________________________________________ZIP_________**

**MAILING ADDRESS:___________________________________________ZIP__________**

**OCCUPATION________________________HOW LONG________SS#________________**
**employer**

**HOME PHONE #_________________________ WORK PHONE#_________________**

**CELL PHONE#___________________________E-MAIL_________________________**

**MARITAL STATUS _single_married_separated_divorced_widowed HOW LONG____**

**PARTNER'S NAME___________________________________ Date of Birth___/___/____**

**OCCUPATION____________________________EMPLOYER______________________**

**OTHERS LIVING IN THE HOME (Names, ages, how related, occupational or school )**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**PERSONAL PHYSICIAN_____________________________PHONE #________________**

**LAST PHYSICAL EXAM__________ MEDICAL PROBLEMS/SYMPTOMS_________**

______________________________________________________________________________

**CURRENT MEDICATIONS___________________________________________________**
**PRIOR HOSPITALIZATIONS_________________________________________________**

**PREVIOUS PSYCHOTHERAPY Therapist location dates**

______________________________________________________________________________

**INSURANCE INFORMATION**

**SUBSCRIBERS NAME_______________________________PLAN__________________**
**CERTIFICATE #____________________________GROUP #______________________**
**REFERRED BY:_______________________________________________________________**