Nurturing Life Concepts, LLC
Wendy A. West Pidkaminy, LCSW-R
Executive Officer
8195 Cazenovia Road, Suite 9
Manlius, NY 13104
(315) 682-4005
www.nurturinglifeconcepts.com

Individual Demographic Form

Today's Date:
Name (First, Middle Initial and Last)
Social Security Number DOB Age
Residential Address:
Home Phone: Cell Phone: Work Phone:
Email address:
May we email, text and or leave messages? NLC will never include any personal or clinical information in such messages, unless the correspondence was initiated, authorized or requested to do so by you. NLC may contact you about missed or rescheduled appointments. Anyone who reads such information or listens to telephone messages would realize that you have come to see NLC for services. Also note that text and email correspondence is vulnerable to interception and is not considered reliably confidential. Know that you are sending info in this manner at your own risk.
You may email me at the following email address:
You may text and or call the following phone number:
Gender: M F T
Education Level:
Marital Status: Married Separated Remarried Divorced Widowed In a relationship other
Immediate Family Relationships/Family Constellation (spouse, children, siblings, parents etc) List each person Name: Relationship Age Location (ie live with you etc)
_____
_____
_____
_____
_____
_____

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Currently Employed or attending school: Y N Employer/School:
Position Held: Length of Time:
Work Address: Work Phone:

Current Allergies: Y N If yes, please describe in detail:
Have you ever been in the military or are you currently enlisted in any branch of the US military? Y N
If you answered yes to the above question, did your military experience include any traumatic or highly stressful experiences which continue to bother you: Y N If yes please list:
Have you ever been convicted of a crime or had legal difficulties? Y N If yes, please describe in detail: _____ _____
Have you ever been identified with a documented disability, including: ADHD_____; Deaf or hard of hearing____; visual impairments____; learning disorders___; mobility impairments____; physical/health related disorders____; neurological disorders_____; psychological disorders_____; Other (please specify):_____ If you checked yes on the above please provide detailed information:_____ _____ _____ _____ _____

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Medical History: (include current medications (prescribed, OTC, and supplements), hospitalizations, medical diagnoses/procedures, allergies, smoking history, caffeine intake, alcohol and drug use/abuse and exercise habits:

_____

_____

_____

_____

_____

_____

Significant Psychiatric History/Current Treatment Y N If YES, please explain

_____

_____

_____

History of suicide attempts, cutting or self mutilation, addictions, disorders? Y N If yes, please explain:

_____

_____

_____

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Reason for Today's Visit:

_____

_ _____

How many days a week does this problem occur? Not occur?

What have you done in the past to assist you in reducing the symptoms, challenges and issues you are currently struggling with?

_____
_____
_____
_____
_____

What are your personal skills, strengths and abilities:

_____
_____
_____
_____
_____

Do you have a support system? If yes, please describe:

_____
_____
_____
_____

What Goals do you wish to accomplish in counseling?-

_____
_____

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_____

Please list anything that was not asked that you feel is pertinent here:

_____

_____

_____

_____

_____