Victoria Leigh Parenti, MA, LPC, NCC
Victoria Leigh, LLC
4612 South Carrollton Ave.
New Orleans, LA 70119
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(504) 256-1454

For the convenience of time, please have this form filled out before the beginning of our initial session. If you are coming as a family, please have this form filled out for each member of the family. Please fill out or circle to the best of your knowledge or ability. The purpose of this form is to provide some background information that will aid in me providing, quality therapeutic services. Once I receive this paperwork along with a signed declaration of practices and procedures, this information will be held with confidence.

Name: ________________________________ **Age:** ______ **Gender:** Male Female Other
Occupation: ______________________________ **Employer:** ______________________________
Student? Yes No **If yes, School:** ____
Total hours at work/school: _______ **Avg. Hours of sleep per night:** _____ **Exercise?** Yes No
Home Address: ____________________________ **City/State/ZIP:** _________________________
Home Phone/Cell: ___________________ E-mail: ______________________________________
Previous marriage(s)? Yes No **If yes, how many?** _____ **Religion:** _______________________
Please list all children from your current or previous marriage and whether or not they are currently residing in your home. Please note that you will only have to fill this part out once per household. If not applicable, please write N/A on the first line.
Name(s) Age Gender Living at home? Medications?
_____________________________ _____ ______ Yes No ___________________
_____________________________ _____ ______ Yes No ___________________
_____________________________ _____ ______ Yes No ___________________
_____________________________ _____ ______ Yes No ___________________
_____________________________ _____ ______ Yes No ___________________
_____________________________ _____ ______ Yes No ___________________
Insurance Provider: _____________________________ **Date of last physical:** ______________
ID Number (on card): _____________________________ **Birth date:** _______________________
Emergency Contact: ____________________________ **Relation:** __________________________
Phone number: ______________________________

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Name of primary care physicians, psychologists, psychiatrists, counselors, social workers, or any other professionals whom you or your family regularly see:

Name(s) Type of practitioner Would you grant permission to consult?

___________________________ ___________________ Yes No
___________________________ ___________________ Yes No
___________________________ ___________________ Yes No
___________________________ ___________________ Yes No

If any, please list any physical or mental health problem that has been identified either now or in the past. Examples of this would be a significant event such as loss, a diagnosed mental health disorder, or a pervasive medical condition:

Name(s) Physical or Mental Health Problem(s)

________________________________ ____
________________________________ ____
________________________________ ____
________________________________ ____
________________________________ ____

Circle any of the following that you or your family has struggled with recently or in the past:

Anxiety
Depression
Physical Abuse
Emotional Abuse
Medical Issues
Sexual Abuse
Financial Strain
Behavioral Issues
Substance Abuse
Sleeping Problems
School Problems
Grief or Loss
Trauma
Suicidal Thoughts
Chronic Fighting
Sex Issues
Divorce
Self-Harm
Infidelity
Social Issues
Family Conflict

Please briefly describe what brings you to therapy:
____
____
____

What are your goals for therapy? ____
How did you hear about me? ____
Signature of individual
filling out form: ____________________________________ **Date:** ___________________