MELISSA LESTER, LCSW
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GROUP ATTENDEE BIOGRAPHY

Date_________________

Name ____ Age ________ Date of Birth______________

Cell phone _________________________________Email ____

Home Address ____
City____ State _____________Zip ______________________

Current or most recent therapist's name ____

Ok to thank them for this referral? Yes_________________________________No________________________

Psychiatric medication prescriber____Phone____________________

Primary care physician____Phone____________________

Medication	Dose	Purpose

Emergency Contacts
1)____Phone____________________
2)____Phone____________________

Gender Identification ____

Sexual Orientation Bi ___ Lesbian ___ Straight ___ Questioning ___ Queer ___ Pansexual____Other_______

Spouse or Partner ___________________________________ Monogamous / Polyamorous

Years of education ____________________Occupation____

Employer____