CLIENT INTAKE

Stephanie De La Torre
M.A., M.F.C.C.

Last Name First M.I. Today's Date

Home Address City State Zip Code

(____)_____ (____)_____ M_____ F_____
Home Phone # Work Phone # Sex

Single__ Married__ Divorced __Separated__

Age Date of Birth Marital Status

Occupation Employer Soc.Security#

Work Address City State Zip Code

SPOUSE/PARTNER

Name of Spouse/Partner Age

_____(____)_____
Occupation Work Phone#

PHYSICIAN

Name

_____(____)_____
Address Phone #

EMERGENCY CONTACT

Name Relationship to you

(____)_____ (____)_____
Home Phone # Work Phone #

HISTORY

Any previous psychological treatment?

_____

If yes, with whom? When?

Please check if there is a history of a : drug problem?___ suicide problem?___
gambling problem? violence?____
alcohol problem?

If yes, briefly explain:_____

Please list any medical conditions or medications you are currently taking

_____

Please list any people living with you and their relationship to you:

_____

If you have any children, how many and what are their ages?

_____

How many brothers and sisters do you have and what are their ages?

_____

Who referred you?_____

Please explain what brings you to therapy at this time:

_____

_____

_____

I understand that upon signing this, I authorize and give permission to Stephanie De La Torre, M. A., M.F.C.C., License # MFC 34770, to evaluate, diagnose and provide psychotherapeutic services as deemed necessary.

_____ _____

Client Signature Date