AMY-LYNN GERBER
Marriage & Family Therapist
LMFT #103970
2820 Glendale Blvd
Los Angeles, CA 90039
(213) 375-5731

CLIENT INTAKE FORM: COUPLES

Intake Date:________________________

Relationship Status:

Dating Living Together Engaged Married Separated Divorced

How were you referred to me? ____

Client 1: Information

Name:____ Date of birth:___________________

Address____
street city state zip

Social Security#: ________________________________

Home Phone:___________________________________ Preferred Ok to leave message?

Cell Phone: _____________________________________

Work Phone: ____________________________________

Email: ____

Employer__________________________________ Type of Work ______________________________

Highest Level of Education Completed: High School Associate Degree Bachelor Degree
Masters Doctorate Other
____

Number of Children Living w/ You: ____ Ages: ____

Number of Children Not Living w/ You: ____ Ages: _______________________________________

Number of Other People Living w/ You:____

Relationship to You + Ages: ____

____

Emergency Contact: ___________________________________Phone: __________________________

Relationship to you: ____________________________

Client 1: Medical History

Primary physician: ____________________________________Phone_________________________

Have you ever suffered a serious illness or injury? ____

____

Do you have a chronic illness or chronic pain?____

____

Please list any medications that you are currently taking and the purpose of each one:_________

____

Client 1: Psychiatric History

Psychiatrist: ____Phone__________________________

Have you recently experienced a very stressful event? ______________________________________

____

Have you received psychotherapy or counseling in the past? Yes No

If yes: when, with who, and for what reason? ____

____

Have you ever been hospitalized for mental/emotional/psychiatric reasons? Yes No

If yes: when, where, and for what reason?____

____

Have you ever received help for alcohol or drug dependency? Yes No

If yes: when, where, and for what substance?____

____

Please list any psychiatric medications (antidepressant, mood stabilizer, etc.) you are currently taking and the purpose of each one:____

____

Client 1: Presenting Problems/Issues

Please circle any concerns that apply to you:

Depression	Alcohol or drug use	Communication problems
Financial concerns	Anxiety, nervousness	Family concerns
Conflicts, arguments	Homicidal feelings	Eating problems
Suicidal feelings	Abuse (physical, sexual)	Work, career concerns
Sleeping problems	Paranoid feelings	Harm to self
Lack of anger control	Stealing	Sexual problems

Please describe the problem or issue for which you are seeking therapy: ______________________

____

____

How long have you had this problem/issue?____

____

____

Why are you seeking help for this problem/issue at this time?_____________________________

____

____

What would you like to see happen as a result of therapy? __________________________________

____

____

____   ______________________
Client 1 Signature   Date

Client 2: Information

Name:____ Date of birth:___________________

Address____
street city state zip

Social Security#: ________________________________

Preferred Ok to leave message?

Home Phone:___________________________________

Cell Phone: _____________________________________

Work Phone: ____________________________________

Email: ____

Employer__________________________________ Type of Work ______________________________

Highest Level of Education Completed: High School Associate Degree Bachelor Degree

Masters Doctorate Other

____

Number of Children Living w/ You: ____ Ages: ____

Number of Children Not Living w/ You: ____ Ages: _______________________________________

Number of Other People Living w/ You:____

Relationship to You + Ages: ____

____

Emergency Contact: ___________________________________Phone: __________________________

Relationship to you: ____________________________

Client 2: Medical History

Primary physician: ____________________________________Phone_________________________

Have you ever suffered a serious illness or injury? ____

____

Do you have a chronic illness or chronic pain?____

____

Please list any medications that you are currently taking and the purpose of each one:__________

Client 2: Psychiatric History

Psychiatric: ____Phone___________________________

Have you recently experienced a very stressful event? _______________________________________

____

Have you received psychotherapy or counseling in the past? Yes No

If yes: when, with who, and for what reason? ____

____

Have you ever been hospitalized for mental/emotional/psychiatric reasons? Yes No

If yes: when, where, and for what reason?____

____

Have you ever received help for alcohol or drug dependency? Yes No

If yes: when, where, and for what substance?____

____

Please list any psychiatric medications (antidepressant, mood stabilizer, etc.) you are currently taking and the purpose of each one:____

____

Client 2: Presenting Problems/Issues

Please circle any concerns that apply to you:

Depression	Alcohol or drug use	Communication problems
Financial concerns	Anxiety, nervousness	Family concerns
Conflicts, arguments	Homicidal feelings	Eating problems
Suicidal feelings	Abuse (physical, sexual)	Work, career concerns
Sleeping problems	Paranoid feelings	Harm to self
Lack of anger control	Stealing	Sexual problems

Please describe the problem or issue for which you are seeking therapy: ______________________

____

How long have you had this problem/issue?

Why are you seeking help for this problem/issue at this time?

What would you like to see happen as a result of therapy?

Client Signature

Date