

AMY-LYNN GERBER
Marriage & Family Therapist
LMFT #103970
Los Angeles, CA 90026
(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: _____

Preferred gender pronouns: _____

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#: _____

Home Phone: _____ Preferred Ok to leave message? Cell Phone: _____ Work Phone: _____

Email: _____

Preferred gender pronouns: _____

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

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 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