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Individual, Marriage and Family Therapy – LMFT-21518

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Date: ____________________________

Patient Name: _______________________________________ SSN: ______-_____-_______
Last First M.I. (optional)

Address: ____

City: ____________________________________ State: ______________ Zip:_______________

Home Phone: (___) _____-_________ Work Phone: (____) _____-___________ Ext:________

Mobile Phone: (___) _____-_________ Pager: (___) _____-_______

Fax: (___) _____-___________ E-mail: ____________________________________

Gender: [____] Male [____] Female Date of Birth: ______-_______-________ Age: _______

Marital Status: [____] Married [____] Single [____] Divorced
[____] Separated [____] Widowed [____] NA (children)

Spouse Patient Name: _______________________________________ SSN: ______-_____-_______
Last First M.I. (optional)

Address: ____

City: ____________________________________ State: ______________ Zip:_______________

Home Phone: (____) _____-_________ Work Phone: (____) _____-___________ Ext:________

Mobile Phone: (____) _____-_________

Gender: [____] Male [____] Female Date of Birth: ______-_______-________ Age: _______

Children:

Name: _________________________________ Sex: _____ Date of Birth: ___________ Age: ___________

Name: _________________________________ Sex: _____ Date of Birth: ___________ Age: ___________

(Over)

Employment Status: [____] employed [____] student [____] unemployed
[____] employed/student [____] homemaker

Employer: ____

Referral Source: ____

Referral Type: ____________________________________(self, family, friend…)

Primary Care Physician:____________________________ Phone: ________________

Residence Situation: ___________________________ (private household, shelter, jail, residential facility)

Household Members: [____] Spouse/Partner [____] Children
[____] Other Family Members [____] Roommate

Educational Level (Highest Grade Completed): _______

[____] less than high school [____] some college
[____] some high school [____] college graduate
[____] high school graduate [____] post-graduate work

Military Service: [____] No [____] Yes If Yes, Status:_ [____] Active
[____] Honorable Discharge
[____] Dishonorable Discharge
[____] Medical Discharge

Religion (optional): [____] Catholic [____] Protestant
[____] Jewish [____] Moslem
[____] Hindu [____] Other

Race (optional): [____] White [____] African-American
[____] Hispanic [____] Native American
[____] Asian-American [____] Other

In Case of Emergency, Contact:

Name:______________________________ Relationship:________________________

Phone:______________________________

If patient is minor:

[____] Mother (or Guardian) [____] Father

Name: ___________________________ ______________________________

DOB: ___________________________ ______________________________

Address: ___________________________ ______________________________

___________________________ ______________________________

___________________________ ______________________________

(H) Phone: ________________________ ______________________________

(W) Phone: ________________________ ______________________________