

Laurel A. Fay, M.S., LCMFT
Licensed Clinical Marriage and Family Therapist
MD License #LCM167
9525 Georgia Avenue, Suite 203 * Silver Spring, MD 20910
240-603-6201 * Fax: 301-588-5870
www.laurelfay.com
laurel@laurelfay.com

CLIENT INTAKE

Today's date _____

Name (both if couple) _____ Date of Birth _____

Address _____

City, State, Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Which number is the best to reach you? _____

Email Address (thereby giving your permission to be contacted via email):

How did you hear about my services? (if from a website, please be as specific as possible):

Occupation (self or parents): _____ Work location: _____
(city, state)

Names and birthdates of children: _____

If relevant, who has legal custody? _____

Whom can I call in case of emergency? _____
Name Phone Relationship

Are you currently being treated by a physician? If so, for what? _____

Physician Name: _____

Current medications, if any: _____

Please list past or present therapists, and dates of service: _____

How do you hope therapy will help you? _____

As you see it, what is bothering you most right now? _____

Has anything like this happened before? When? _____

What led you to seek help at this time? _____

How would you like to change things? _____
