Laurel Fay & Associates, LLC

Licensed Marriage and Family Therapists

8720 Georgia Avenue, Suite 308 | Silver Spring, MD 20910

4325 Northview Drive | Bowie, MD 20716

301-563-9520 | fax: 301-747-1859

www.laurelfay.com | info@laurelfay.com

CLIENT INTAKE

Please Print -- Use the back side if you need more room

Today's date: _____ Your therapist's name: _____

Name: _____ Date of Birth: _____

Phone: 1st _____ H C W 2nd _____ H C W

Address: _____

City, State, Zip:_____

Email Address: _____

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

_____

Occupation (self or parents): _____ Work location: _____

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? _____