Margaret Grundstein | M.F.T.

CLIENT INFORMATION FORM

NAME:_____ DATE _____

FAMILY COMPOSITION (List you and other family members who may be involved in treatment)

Name Age Date of Birth Birth Place Education Occupation or Current School

_____

_____

_____

_____

ADDRESS _____

CITY/ZIP _____

HOME PHONE # _____BUSINESS # _____CELL#_____

At which of these numbers may I leave messages? _____

May I contact you by mail? YES ____ NO ____ By e-mail? YES ____NO_____ By text? YES_____NO_____

DRIVER'S LIC _____E-MAIL ADDRESS_____

MARITAL STATUS _____ CHILDREN/ AGES _____

WITH WHOM DO YOU LIVE? SPOUSE _____ PARENTS _____ OTHER _____

PLEASE LIST ANY CURRENT HEALTH PROBLEMS

_____

PLEASE LIST ANY MEDICATIONS AND DOSAGES

_____

PHYSICIAN'S NAME/ PHONE # _____

HAVE YOU BEEN HOSPITALIZED FOR PSYCHOLOGICAL REASONS OR DRUG DEPENDENCY?

YES _____ NO_____ If yes, please describe _____

NAME/ NUMBER OF PSYCHIATRIST (If Applicable) _____

ISSUES THAT BRING YOU TO THERAPY

_____

PRIOR THERAPIST (S) AND LENGTH OF THERAPY

_____

REFERRED BY _____ PERMISSION TO ACKNOWLEDGE? _____

Adult, Child and Family Therapy
11340 W. Olympic Blvd.
Suite 381
Los Angeles, California
90064

MFT LICENSE #50240

310 313 2979