

Eveline Smilack, MFA, LMFT
Licensed Marriage & Family Therapist #91090
Practice of Psychotherapy

270 26th Street, Suite 205
Santa Monica, CA 90402
(310) 869-1533

CLIENT INFORMATION

Name : _____ DOB: _____

Address: _____

CITY: _____ ZIP: _____

SS#: _____ Home #: _____

Email: _____ Cell #: _____

(Please circle your preferred telephone contact number)

Marital Status: _____

Name of Spouse/Partner: _____

Children (Names & Ages): _____

Occupation: _____

Employer: _____

Emergency Contact Name: _____

Emergency Contact Address: _____

Emergency Contact Phone #: _____

Referred By: _____

Why are you seeking
therapy at this time?

Problems in work life?

Problems in relational life?

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If therapy is helpful, how will your life change? _____

Previous Psychotherapy: _____

With whom/when: _____

Psychiatric Hospitalizations: _____

Date and reason for admit: _____

Have you ever made a suicide attempt? _____

If so, please indicate date and method used: _____

Are you currently having suicidal thoughts: Yes _____ No _____

Medication (Purpose of each; for example, anxiety, high blood pressure, etc.): _____

PLEASE INDICATE ANY OF THE FOLLOWING THAT CURRENTLY APPLY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Problem | <input type="checkbox"/> Drinking Problem |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Drug Problem | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Injuries/Accidents | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Explosive Anger |
| <input type="checkbox"/> Disordered Sleep | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Significant Weight Change |

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**Other
Symptoms:** _____

I have completed this client information form truthfully and to the best of my abilities.

Name (Print): _____ **Date:** _____

Signature: _____

Guardian (Adolescent/Dependent)

Name (Print): _____ **Date:** _____

Signature: _____

As Witnessed By Therapist:

Name (Print): _____ **Date:** _____

Signature: _____