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:

[ ] Headaches	**[ ] Digestive Problem**	**[ ] Drinking Problem**
[ ] Fatigue	**[ ] Drug Problem**	**[ ] Dizziness**
[ ] Depression	**[ ] Panic Attacks**	**[ ] Nightmares**
[ ] Insomnia	**[ ] Memory Problems**	**[ ] Allergies**
[ ] Poor Appetite	**[ ] Ulcers**	**[ ] Poor Concentration**
[ ] High Blood Pressure	**[ ] Injuries/Accidents**	**[ ] Anxiety**
[ ] Thyroid Problems	**[ ] Heart Condition**	**[ ] Cancer**
[ ] Irritable Bowel	**[ ] Disordered Eating**	**[ ] Explosive Anger**
[ ] Disordered Sleep	**[ ] Skin Condition**	**[ ] Fibromyalgia**
[ ] Sexual Problems	**[ ] Restless Leg Syndrome**	**[ ] Arthritis**
[ ] Hyperactivity	**[ ] Impulsivity**	**[ ] Hopelessness**
[ ] Decreased Energy	**[ ] Diabetes**	**[ ] 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: _____