JEFF ADORADOR, LMFT 80129

LICENSED MARRIAGE AND FAMILY THERAPIST

(530) 401-3894 jadoradorlmft@gmail.com

INTAKE FORM

Date:_____

Name:_____Age:_____ DOB:_____

Address:_____

Contact Number(s): Cell: (_____)_____ Other: (_____)_____

E-mail address:_____

EMERGENCY CONTACT: _____

Name of Additional Participates of Counseling: _____

Billing Insurance: ____ Yes ____ No If so, please provide name: _____

Marital Status: ____ Single ____ Engaged ____ Married ____ Separated ____ Divorced

Name of Spouse:_____

Number of Children & Ages: _____

Presently Living with: ____ Parents ____ Spouse ____ Roommate ____ Alone ____ Other

Education:_____Occupation:_____

Currently Working: ____ Yes ____ No

Do you have a distracting Medical Issue? ____ Yes ____ No

If so, please explain._____

Have you ever been diagnosed with a mental health disorder? ____ Yes ____ No

If so, please explain._____

Are you currently on psychiatric medication? ____ Yes ____ No

If so, please explain._____

Do you have a history of suicidal ideations, attempts or hospitalization? ____ Yes ____ No

If so, please explain._____

Are you currently suicidal: ____ Yes ____ No

Do you have a history of drug use or abuse? ____ Yes ____ No

If so, please explain._____

Primary Reason for Counseling:

_____

_____

_____