Andrew Lawrence Lande, M.A.
Licensed Marriage and Family Therapist

CLIENT CONTACT INFORMATION

DATE:_____

NAME:_____

AGE:_____DATE OF BIRTH:_____GENDER:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PRIMARY PHONE:_____ ☐Cell ☐Landline
OK to leave messages? ☐YES ☐NO OK to text? ☐YES ☐NO

SECONDARY PHONE:_____☐Cell ☐Landline ☐Work
OK to leave messages? ☐YES ☐NO OK to text? ☐YES ☐NO

EMAIL:_____
May I email you? ☐YES ☐NO
*Please note: Email and text correspondence are not considered a confidential form of communication.

Are you currently employed? ☐YES ☐NO
If yes, please list:
OCCUPATION:_____
PLACE OF EMPLOYMENT:_____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

NAME OF SPOUSE / PARTNER: _____

EMERGENCY CONTACT:_____
RELATIONSHIP TO CLIENT:_____
PRIMARY PHONE: _____☐Cell ☐Landline ☐Work
SECONDARY PHONE:_____☐Cell ☐Landline ☐Work

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License LMFT 106800

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CLIENT INTAKE INFORMATION

Date of first appointment: _____

Please provide the following information. The questions are designed to help me get to know you better so that our time together can be as productive as possible. If you find the available space for any response to be insufficient, feel free to continue on the reverse side of the form. Please bring this form with you to your first appointment.

Referred by:
☐ Medical Provider: _____
☐ My website: http://www.andrewlandemft.com
☐ Psychology Today
☐ Friend/Family: _____
☐ Other: _____

Education Level:_____

Are you currently in a romantic relationship or marriage? ☐Yes ☐No
If yes, how long have you been in current marriage or romantic relationship:_____
On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

Mental Health
Have you previously received any type of mental health services? ☐Yes ☐No
If yes, when? Please briefly list the reasons.
_____
_____
_____
_____

Please describe the results of treatment or whether it is ongoing. Please include what you found to be most helpful about this treatment and anything you found to be least helpful or unhelpful.
_____
_____
_____
_____
_____

Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No
If yes, what are you experiencing and when did it begin?
_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, when and circumstances that led to the attempt(s)?
_____
_____

_____

Are you presently having suicidal thoughts? ☐ Yes ☐ No
If yes, please describe?

_____
_____
_____

Have you ever been prescribed psychiatric medication or are you currently taking any medication(s) to treat mental health issues? ☐ Yes ☐ No
If yes, please list medication name, dosage, condition treated, and date prescribed or discontinued:

Medication	**Dosage**	**Condition Treated**	**Date Prescribed or Discontinued**

Please list your past and present alcohol and substance use history:

Drug Type	**Frequency**	**Date Last Used**
Alcohol	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Marijuana	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Cocaine	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Amphetamines	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Opiates	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Benzodiazepines	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Psychedelics Specify:	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
Others: Please Specify Drug Name:	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	
	☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never	

Please describe any major losses or traumas you have experienced throughout your lifetime and the approximate age at which you experienced it:

_____
_____
_____
_____
_____

Have you recently experienced any significant life changes or stressful events? If so, please describe them including any of the following: deaths, serious illness, psychiatric disorder, financial crisis / unemployment, divorce, physical/sexual abuse, alcohol/drug abuse, legal problems, eating disorders.

_____
_____
_____
_____
_____
_____

What is your primary reason or concern for seeking therapy? Please include any specific symptoms you are experiencing and when you first noticed those symptoms.

_____
_____
_____
_____

What would you like to accomplish through therapy? Please include any specific goals you may have:

_____
_____
_____
_____

Physical Health

Are you currently under the care of a medical doctor? ☐ Yes ☐ No
When was your last complete physical examination? _____
How would you rate your current physical health?

☐ Poor
☐ Unsatisfactory
☐ Satisfactory
☐ Good
☐ Very Good

How would you rate your current sleeping habits?

☐ Poor
☐ Unsatisfactory
☐ Good
☐ Very Good

If you are having sleep problems, in which phase of sleep are you experiencing issues?
Check all that apply

☐ Falling asleep
☐ Staying asleep
☐ Awakening early
☐ Sleep apnea

Please list any other specific sleep problems you are experiencing:

_____
_____

How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

_____

Are you currently experiencing any chronic pain? ☐ Yes ☐ No
If Yes, please describe:_____
_____
_____

Please list current medications, herbs, or supplements, including the condition for which they have been prescribed or being taken.

Medication / Supplement	Dosage	Condition(s) Treated

If you would like to provide additional relevant physical health information, please use the reverse side.

Family History
Where were you born? _____
Where did you grow up? _____
☐ City
☐ Suburbs
☐ Country

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	Where they live now?	If deceased, age and cause of death?

Who did you live with while growing up? _____
Mother's occupation? _____
Father's occupation? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	**Please Check**	**List Family Member**
Alcohol/Substance Abuse	☐Yes ☐No	
Anxiety	☐Yes ☐No	
Depression	☐Yes ☐No	
Bipolar Disorder	☐Yes ☐No	
Domestic Violence	☐Yes ☐No	
Sexual Abuse	☐Yes ☐No	
Eating Disorders	☐Yes ☐No	
Obesity	☐Yes ☐No	
Obsessive Compulsive Disorder	☐Yes ☐No	
Schizophrenia	☐Yes ☐No	
Suicide Attempts	☐Yes ☐No	
Please List Any Other Diagnosed Mental Health Conditions:	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	
	☐Yes ☐No	

Do you have children? ☐ Yes ☐ No
If yes, please list their name(s) and age(s):

_____
_____

Additional Information
What are the top three stressors in your life?
1) _____
2) _____
3) _____

Do you enjoy your work? ☐Yes ☐ No
Is there anything stressful or challenging about your current or past work experience?

_____
_____

Are you currently experiencing a predominant emotion? ☐Yes ☐No
If yes, please describe it? _____

Are you currently experiencing a full range of emotions? ☐Yes ☐No
If yes, please elaborate below:

_____
_____

When you are feeling stressed do you notice any behavioral or physical signs? ☐Yes ☐No
If yes, please describe:

_____
_____

What is your relationship to your body? Love it? Hate it? Somewhere in between?

_____

If fully energized, passionate, and loving my life is a 1, and fried to a crisp is a 10,
Where would you put yourself right now? _____

What are three things that can always make you smile?
1) _____
2) _____
3) _____

What are three things that relax you?
1) _____
2) _____
3) _____

Do you have any religious or spiritual practices? ☐Yes ☐No
If yes, what helps you feel more connected to it?_____

_____
_____

What do you enjoy doing in your free time?

_____
_____

What do you consider to be some of your strengths?

_____
_____
_____

What do you consider to be your biggest challenges?_____

_____
_____
_____

Can you think of times when your problem(s) is not a problem?_____

_____
_____

_____

What would your life look like without the problem(s)?_____
_____
_____
_____

Please provide any additional relevant information you wish to share below.