DR. SHEILA M. ADDISON
Licensed Marriage and Family Therapist ♦ LMFT #49616
1900 Addison St., Suite 200 ♦ Berkeley, CA 94704 ♦ (510) 599-5467
drsaddison@gmail.com ♦ http://www.drsheilaaddison.com

Client Information Form

Today's Date:__________________ **Name:** ________________________

What concerns led you to seek out therapy?___________________________________
____
____

A. Identification

Name ____________________________________ DOB ____________ Age _______
Gender ___________ Pronouns: ____________________ SSN: __________________
Address ____
City _______________________________ State ______ Zip ____________________
Home phone________________________
Cell phone _________________________
Email ____
Please indicate any restrictions on phone calls, messages/voice mails, or emails:
____

B. Family Information

Relationship Status
___ Single ___ Engaged ___ Married ___ Living Together ___ Domestic Partners
___ Separated ___ Divorced ___ Widowed ___ Poly relationship

Children (include launched/adult children, and any minors living in your household)

Name	Age	Relationship	Gender

C. Medical Care: Are you currently under the care of a doctor for any physical or mental condition? If so, for what?
____
____
____

Current medications (dose, purpose)
____
____
____

Primary care doctor: ____

DR. SHEILA M. ADDISON
Licensed Marriage and Family Therapist ♦ LMFT #49616
1900 Addison St., Suite 200 ♦ Berkeley, CA 94704 ♦ (510) 599-5467
drsaddison@gmail.com ♦ http://www.drsheilaaddison.com

D. Employment:
Employer ______________________________ Position__________________________
Work phone ____________________________ Call/message OK? ________________

E. Emergency Contact Information

Name: ________________________________ Phone____________________________
Relationship to you: ____

F. Child Information (list more children on additional sheet):

Child's name ____ DOB: ___________________
School, grade ____
Primary care physician ____
Medical problems ____
____
Other providers involved in child's care ____________________________________
____
Medications (dose, purpose) ____
____
____

G. Referral: How did you find out about me? _____________________________________

If you found me on the Internet, where did you find a link or what did you search for?
____

What made you feel I might be a good therapist for you? ____________________________
____

If you were referred by someone, may I thank them for the referral?
Yes _________ No _________ Name/phone _________________________________

H. Other:

Are you interested in receiving occasional (1-4 times per year) newsletters about my practice via email? Yes ___________ No _________

Are you willing to receive a follow-up survey in the mail about your treatment after your therapy ends? Yes _________ No _________