

Nahid Ghajar M.A. LMFT 949-813-1924
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Client Intake

Name _____ Today's Date _____

Address _____ Age ____ Birthdate _____

City _____ Zip _____

Phone (home) _____ Cell _____

Where may I leave you a message? Home _____ Work _____ Cell _____

Employer _____ Job Title _____ Monthly Income _____

Education _____ (*Last grade completed*) School _____

Major _____ Date Graduated _____

Spouse _____ Age ____ Birthdate _____

Employer _____ *Job Title* _____

Education _____ (*Last grade completed*) *Major* _____

Religious Affiliation _____ Ethnicity _____

How were you referred to me? _____

Prior therapist _____ Dates of treatment _____

Presenting Problem (*Why you are looking for counseling or therapy today*)

Emergency Contact _____ Phone # _____

Someone I have permission to contact in case of Emergency

Client Signature _____

Children:

Name & Age	Live with you?	Birthdate	Other Parents Name
1.			
2.			
3.			
4.			
5.			

Are your parents still married? _____ Your birth order _____ (1st child etc.)

Quality of relationship with parents' _____

Special Issues or concerns with parents _____

Siblings:

Name	Age	Live with you?	Quality of Relationship
1.			
2.			
3.			
4.			
5.			

Special Issues or concerns with siblings _____

Legal Issues _____

Medical Issues _____

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Are feeling like hurting yourself today? _____

Are feeling like hurting someone else today? _____

Please list medication you are taking & dosages

Medical Doctor _____ Last Seen? _____

What would you like me to help you with?

List with #1 as the most important.

1. _____

2. _____

3. _____
