Sharon Kane LMFT

Marriage and Family Therapist
License No. 51215
(310) 963-6736
sharon@sharonkanemft.com

Patient Questionnaire/Intake

Name	_____	**Date**	_____
Address	_____	**Phone - home**	_____
	_____	**Phone - cell**	_____
Email	_____	**Referred by**	_____
Date of Birth	_____	**Occupation**	_____
Emergency Contact	_____	**Phone**	_____

(Please note that if any of the following information is of particular sensitivity, please feel free to leave those items blank and we will discuss them together).

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

_____

_____

_____

_____

Present Relationship Status:

_____ Married/Significant Other

_____ Committed Relationship

_____ Single

_____ Divorced/Relationship Dissolved (how long?)_____

_____ Widowed/Death of Partner (how long?)_____

_____ New Relationship (how long?) _____

Others living in your household:

Names _____ _____ _____ _____

Relationship _____ _____ _____ _____

Age _____ _____ _____ _____

Psychological History

Have you ever received mental health treatment before?_____

When and for how long? _____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long?_____

Why were you hospitalized? _____

Have you ever attempted suicide? _____ When?_____

Are you currently having any suicidal thoughts?_____

Medical History

Are you currently taking any prescription medications?_____

If you are currently have any physical symptoms, please describe _____

_____

Please describe your overall health today. _____

_____

Have you ever been in a 12-step program? Please describe._____

_____

Thank you.

Signature: _____ **Date:** _____