# Sharon Kane LMFT

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# Patient Questionnaire/Intake

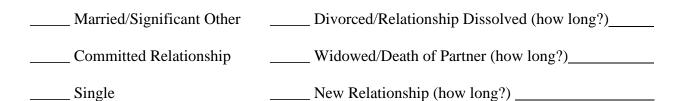
Name	Date
Address	Phone - home
	Phone - cell
Email	Referred by
Date of Birth	Occupation
Emergency	
Contact	Phone

(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:**



### Others living in your household:

Names	
Relationship	
Age	
<b>Psychological History</b> 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?	
<b>Medical History</b> 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: \_\_\_\_\_