

Lauren Boasberg
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General Information

Name _____

Date _____ Date of birth _____ Age _____

Address _____

City: _____ State _____ Zip Code _____

Home phone _____ work _____ Cel _____

Email: _____

Referred by: _____

Education: _____ Highest degree completed: _____

Current Occupation/employer: _____

Contacts

Emergency contact _____ phone # _____

Relationship to you _____ other # _____

Other people living in your household and their relationship to you

Family (circle one)

- Married
- Single (how long)?
- Divorced (how long)?
- Dating
- Widowed
- In a new relationship (6 months or less)
- Other

Medical

Date of last physical exam _____ Doctors name _____

General health is Excellent Good Fair Poor

Do you presently take any medications/herbal supplements, birth control pills, etc?

Please describe any physical/medical problems you presently experience

Are you now or have you ever been under the care of a psychiatrist? Y/N

Are you now or have you taken medication for a psychological issue (depression, anxiety, etc.)

Therapy

Why are you seeking therapy today?

What are you hoping to gain from therapy?
