Devorah Rodgers, LMFT #42720

566 S. San Vicente Blvd., Ste. 203
Los Angeles, CA 90048
310/592-2004

Initial Therapy Intake Form

Name _____

Age _____ **Birthdate** _____

Social Security #: _____

Address _____

_____

Email _____

Home Phone _____

Work Phone _____

Cell Phone: _____

Occupation _____

Employer _____

Marital Status _____

If Client is a Minor, Name of Responsible Adult:

_____

Name/Phone Number of Closest Friend/Relative

_____

There are times when prior medical and psychological records will be requested.

Are You Now Under a Doctor's Care? _____

If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication? _____

If yes, what kind? _____

Reason for Medication: _____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, Substance Abuse, Eating Disorder, etc? Describe:

_____

_____

Any Previous Therapy/Counseling? _____

When and Number of Sessions: _____

What do you wish to Achieve with Therapy? _____

_____

_____

Who referred you to Devorah Rodgers, MFT?

_____

I declare all the foregoing information is true and correct.

_____

Client Signature **Date**