Marty A. Simpson, LMFT, CSAT CDWF
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Patient Intake Questionnaire

	Please complete
Appt. Date	
Name	
Age	
Birthdate	
Gender	
Address	
Home phone	
Cell Phone	
Work Phone	
Fax	
Email	
Marital Status	
Education	
Occupation	
Referred By	

People living in your household:

Name	Relationship	Age

Emergency contact information:

Name	Relationship	Phone Number

☐	It is ok for therapist to leave a message for me via...
	Voice mail on home phone
	Voice mail on cell phone
	Text on cell phone
	Voice mail on work phone
	Email

Financial Information	
Annual household income from all sources (salary, spouse's income, child support, spousal support, investment income)	

Financial Information	
Rent or Own your home?	
How do you intend to pay for treatment?	cash check credit card

Areas of Concern

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

Under what conditions do your problems get better?
Under what conditions do your problems get worse?

Do you have any specific goals with regard to your treatment?

Do you have any particular concerns/fears with regard to treatment?

Are you currently experiencing any health issues? Yes No Please describe:

Are you on any prescription medications Yes No Please describe:

Is there anything else you'd like me to know before we begin our work together?

I look forward to working with you.

Warmly,
Marty