Vonda ("Vondie") Lozano, Ph.D. LMFT
Licensed Marriage & Family Therapist
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(626) 215-2527

INTAKE FORM

_____/_____/_____/_____/_____
Last name First MI Age Birthdate Today's date

Address: _____
Street City Zip

Telephone:_____
Home Work Cell

Occupation/Employer:_____
School/Program (if student):_____
May therapist contact you and/or leave a message at home? Yes _____ No_____
May therapist contact you and/or leave a message at work? Yes _____ No_____
May therapist contact you and/or leave a message on your cell? Yes _____ No_____
Marital Status (circle one):Single/Living Together/Married/Separated/Divorced/Widowed
Length of present marriage: _____ Number & Length of prior marriages:_____
Spouse's name: _____Spouse's work phone: (___) _____
Emergency contact person: _____ Phone:(___) _____
Address: _____

Names of people living in your home (include all children even if they do not live in the home at this time)

Name	Relationship	Age	School/Occupation

Current medical problems:_____
Medications and dosages you are currently taking: _____
Physician: _____Phone (___) _____
Address:_____
Reason for seeking counseling at this time: _____
_____
Referred by: _____
May I contact them to thank them for the referral? Yes _____ No _____
If Yes: Phone (___) _____ Address: _____
Previous counseling: Yes _____ No_____ Dates: _____
Counselor:_____ Phone (___) _____
Address: _____
Psychiatrist:_____ Phone (___) _____
Address: _____

_____ _____
Date Client