Susan Farber, MFT
Embrace Change and Transformation

INTAKE INFORMATION

Name ____________________________ Birthdate ____________ Sex (circle) Female Male

Address _______________________________ Soc. Sec. # ___________________________

_______________________________ Home Phone __________________________

_______________________________ Cell Phone ___________________________

Occupation (circle): Employed Student Other _______________________________________

Employer or School _________________________ Phone _______________________________

Address ________________________________ Extension ____________________________

_________________________________ Who referred you? ____________________

Primary Care Doctor _________________________ Phone Number _______________________

Date of last physical ____/______/_____ Medications __________________________

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History

Presenting Problem ____

Previous Psychotherapy (circle) yes no If yes, when/whom? ____________________________

Major Illnesses ____

Significant Other and Family Members

Name	Birthdate	Relationship	Living at home
__________________________	______________	________________	yes no
__________________________	______________	________________	yes no
__________________________	______________	________________	yes no
__________________________	______________	________________	yes no

PERSON RESPONSIBLE FOR THE ACCOUNT ______________________________

Address _________________________________ Phone ______________________________

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Signature ___________________________________ Date ______________________________

In case of an emergency, contact _______________________ Phone ________________________