Sabrena Swain, M.A., MFT **(916) 685-5258 x22**
Licensed Marriage & Family Therapist 8861 Williamson Dr., Suite 40
License # MFC 42517 Elk Grove, CA 95624

Please fill out the following intake information as completely as possible. Thank you.

Client: _____ Birth date: _____ Age: _____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Work: _____ Cell: _____

Email:_____

Spouse/Parent:_____ Birth date: _____ Age: _____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Work: _____ Cell: _____

Email:_____

If additional space for a parent is needed see page 3.

Single ___ Married ___ Divorced ___ Widowed ___ Date _____

Employer: _____ Spouse's Employer: _____

Insurance/Employee Asst. Program: _____

Insurance I.D. # _____ Group #_____

Subscriber SS # _____

Secondary Ins: _____

Insurance I.D. # _____ Group #_____

Subscriber SS # _____

Emergency Contact (Name/Phone #) _____

Children Full Name Age Living at home? (Y/N)

1._____

2._____

3._____

4._____

How were you referred to me? _____

Reason for seeking counseling today

_____

_____

Any previous counseling? (Who? When? How long? Outcome)

_____

_____

Currently or previously are there any alcohol or substance issues/concerns:

_____

_____

Have you suffered any abuse? (Sexual – Physical – Emotional/Verbal)

_____

Medical Conditions (history, current condition, changes in condition):

_____

_____

Current Medications (dosage, dates of initial prescriptions):

_____

_____

Any religious affiliation?_____

Signature:_____ Date:_____

Parent:_____ Birth date: _____ Age: _____

Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ Work: _____ Cell: _____

Email:_____