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Please complete the information below. All information is CONFIDENTIAL.

Client Information Packet:

Pages 1-2 Client Information - Please Complete

Pages 3-4 Policies and Consent -Please Read and Sign

Page 5 Therapy Partner Account Set Up-Please Complete

Today's Date _____

Referred By _____

Patient Information

Name: _____ **Date of Birth:** _____ **Gender:** _____

Sexual Orientation: _____

Address: _____ **City** _____,
State _____, **Zip** _____

Telephone Numbers: Home: _____ **Cell:** _____ **Work:** _____

Email Address: _____

Employer: _____ **Occupation:** _____

Job Satisfaction: High to Low: _____

Years employed with this company: _____ **Years in Self Employment:** _____

Education Obtained: _____

Reason for Consultation

Briefly describe your reason for seeking my services at this time. _____

What would you most like to address in our work together? _____

Have you been in therapy before? If so, please describe the reason for therapy at that time and whether you felt positively about your experience.

Relationship Information

Are you single? _____ Married/Partnered? _____ If so, number of years _____ Separated/Divorced? _____
If so, for how long? _____

Name of Spouse/Partner: _____

Names & ages of Children: _____

Are you presently involved in any custody disputes? Yes__ No__

Are you presently involved in any legal disputes /lawsuits/divorce/custody/workers comp? Yes__ No__

Health History

Do you have any major illnesses or disabilities? _____

Doctor's Name: _____

Have you seen a psychiatrist in the past five years? _____

Doctor's Name/Phone: _____

What medications do you currently take? _____

Circle your answer:

Do you smoke? Yes no

Drink alcohol? Never Monthly Weekly More than 3 days a week Daily

Drugs? Never Monthly Weekly More than 3 days a week

Have you ever been hospitalized for treatment of a psychological condition or substance abuse problem? Yes
No If so, briefly describe the outcome and treatment

Family History

Are you adopted? YES NO If yes, please indicate your age, placements and any contact you have had with
bio. parent?

Did you grow up with your biological parents? YES NO If no, please describe your living situation:

Were there any major separations from your parents or traumatic events that you identify such as divorce;
illness, hospitalization of parent or sibling; marital separations; moves etc.

Give a brief description of your relationships with the following persons and note any significant health/psychological history such as alcoholism, depression, anxiety, suicide attempt etc.

Mother _____ Father _____

StepFather: _____ StepMother: _____

Sibling _____ Sibling _____

Spouse/Partner _____ Ex Spouse/Partner _____

Child _____ Child _____

Additionally, I would like you to know.....
