



Building healthy relationships one day at a time.

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GENERAL INFORMATION

Today's Date _____

Client's Name _____ Referred by _____
Address _____ email address: _____
City _____ Zip _____ Social Security # _____
Home Phone _____ Birthdate _____ Age _____
Cell phone _____ Driver's License # _____

EMPLOYMENT

Occupation _____ Work Responsibilities _____
Employer _____ Work phone _____
Address _____
City _____ Zip _____

PERSONAL / FAMILY INFORMATION

Marital Status _____ If married, anniversary date _____
Partner's Name _____ Partner's Age _____ Partner's Occupation _____
Length of current marriage/relationship _____ Number of previous marriage(s) _____ Length of each _____
Names/ages of children (this marriage) _____
Names/ages of children (previous marriage(s)) _____
Who has legal custody? physical custody? what is visitation arrangement? _____

Emergency Contact, if those in house cannot be reached:

Name _____ Relationship _____ Phone _____ Cell _____

OVER

CONFIDENTIAL PSYCHOLOGICAL/MEDICAL HISTORY

Purpose for today's consultation: _____

Are you CURRENTLY seeing another psychotherapist or counselor? _____

If so: Name _____ Phone _____

For how long? _____ For what purpose(s)? _____

Have you PREVIOUSLY been in psychotherapy or counseling? _____ If so: When? _____

For how long? _____ For what purpose(s)? _____ Results _____

Are you CURRENTLY involved in a legal procedure? _____ If so, does it concern your seeking counseling? _____

If you have had difficulties with any of the following, please explain:

_____ Alcohol, drug, or tobacco dependence or frequent use? _____

_____ Eating disorder(s)? _____

_____ Other addictive or compulsive behavior(s)? _____

_____ Depression or suicidal thoughts? _____

_____ Anxiety or panic attacks? _____

_____ Anger, arguments, domestic violence? _____

_____ Marital, relationships, or family (current or childhood)? _____

_____ Learning disabilities/problems or ADD/ADHD? _____

Please list stressful situations in your history (accident, hospitalization, separation from loved ones, traumatic event, etc.)

What have you found has been helpful to you when you have felt depressed, anxious, etc.?

Please list ALL prescription medications you are CURRENTLY taking:

Please list any PREVIOUS medications you have taken for psychological purposes:

Amount of CURRENT use: Tobacco _____ Alcohol _____ Caffeine (coffee/cola/chocolate) _____

Sugar _____ Other drugs (marijuana, cocaine, etc - specify) _____

Other physical or medical conditions: _____

Date of last medical exam _____ Doctor's Name _____ Phone _____

Other useful information to assist in counseling: _____