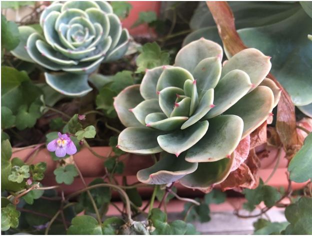

AMBER MARTIN
LICENSED MARRIAGE & FAMILY THERAPIST

INDIVIDUALS, COUPLES AND WOMEN'S EMOTIONAL WELLNESS
AMBER MARTIN, M.A., LMFT- OWNER
LICENSE #104655

2121 41ST STREET, SUITE 205
CAPITOLA, CA 95010
(626) 234-5113

AMBER@AMBERMARTINMFT.COM
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New Client Information

Client's Name:		Date:	
Gender: Please specify _____________		Age:	Date of Birth:
Home Street Address:		City:	Zip
Home Phone:	☐ OK to leave messages?	Mobile Phone:	☐ OK to leave messages?
Work Phone:	☐ OK to leave messages?	Preferred Phone:	☐ home ☐ mobile ☐ work
Email:			
Who referred you to us, or how did you find us?			

Emergency Information

Emergency Contact Name:	Phone Number:	Relationship:
Primary Care Physician Name:	Phone Number:	
Psychiatrist Name:	Phone Number:	

Current Medications - Prescription & Over-the-Counter: (use the back if you need more space)

Medication Name	Purpose	Dosage	Side Effects
Briefly describe your reason for seeking therapy:			

Relationships

□ Single / never married □ Legally married / Domestic Partnership □ Unmarried, living together	□ Separated / Divorce in progress □ Divorced □ Widowed
Length of Current/Most Recent Relationship:	

Current Family: (use the back of the sheet if you need more space)

Relationship	Name	Age	Living	Living with you
Spouse			Yes □ No □	Yes □ No □
Children			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □

Family of Origin: (use the back of the sheet if you need more space)

Relationship	Name	Age	Living	Living with you
Mother			Yes □ No □	Yes □ No □
Father			Yes □ No □	Yes □ No □
Siblings			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □
			Yes □ No □	Yes □ No □

Family History of Mental Illness?	Yes □ No □
Briefly Explain:	

Personal History:

Religious/Spiritual Affiliation:

Please list any current health problems:

Have you engaged in therapy before?	Yes □ No □
Briefly describe the services you received and your feelings about treatment:	

For Women:

History of Experience		Year(s)
History of Miscarriage(s):	Yes ☐ No ☐	
History of Postpartum Depression:	Yes ☐ No ☐	
History of Postpartum Anxiety:	Yes ☐ No ☐	
History of Postpartum Obsessive Compulsive Disorder:	Yes ☐ No ☐	
History of Postpartum Bipolar Disorder:	Yes ☐ No ☐	
Briefly describe any relevant OBGYN history of concerns:		

What do you feel are your strengths as a person?

Please note your experience with each of the following issues, by marking None, Mild, Moderate or Severe and the year(s) in which you experienced the issue.

None	Mild	Moderate	Severe	Issue or Concern	Year
☐	☐	☐	☐	Anger / temper problems	
☐	☐	☐	☐	Anxiety, nervousness or excessive worry	
☐	☐	☐	☐	Behavior problems (specify on back)	
☐	☐	☐	☐	Depression	
☐	☐	☐	☐	Lack of concentration, confusion, indecision	
☐	☐	☐	☐	Eating problems	
☐	☐	☐	☐	Fears, phobias	
☐	☐	☐	☐	Financial problems	
☐	☐	☐	☐	Health problems (specify on back)	
☐	☐	☐	☐	Learning or school problems	
☐	☐	☐	☐	Legal problems	
☐	☐	☐	☐	Memory difficulties	
☐	☐	☐	☐	Over-activity or hyperactivity	
☐	☐	☐	☐	Panic attacks	
☐	☐	☐	☐	Parenting problems	
☐	☐	☐	☐	Relationship problems (with whom)	
☐	☐	☐	☐	Sleeping problems	
☐	☐	☐	☐	Social difficulties	
☐	☐	☐	☐	Substance abuse/addiction (specify on back)	
☐	☐	☐	☐	Sexual problems	
☐	☐	☐	☐	Suicidal notions/attempts	
☐	☐	☐	☐	Thought disorganization and confusion	
☐	☐	☐	☐	Tiredness, low energy	
☐	☐	☐	☐	Work stresses or concerns	
☐	☐	☐	☐	Violence against others (physical harm of any kind)	
☐	☐	☐	☐	Other problems (specify on back)	

Your Signature

Date