Joshua Lowe, LMFT
holistic psychotherapy

LMFT# 105893
6233 Soquel Dr. Suite B
Aptos, CA 95003
(831) 425-3346
joshualowemft@gmail.com

PSYCHOTHERAPY SERVICES INTAKE AND ASSESSMENT FORM

Name: ______________________________________ Date: __________________

Address: ____

Date of Birth: ________ Age:_____

Cell Phone: ____________ Message ok? yes/no Home Phone: ___________ Message ok? yes/no

Email: ____________________________________ Preferred Form of Contact? Cell/Home/Email

Emergency Contact: ____________________ Phone: _____________ Relationship: _______________

Referred by: ____

Type of Therapy: Individual ___ Couples ___ Family ___ Group ___

Married or Relationship?/Length: ______________________ Occupation: ______________________

Past/Present Medical Care (major or chronic problems, accidents, hospitalizations):

____

Past/Current Medications: ____

Past/Present Counseling, Psychotherapy (specify therapist, general dates, issue treated, outcome):

____

Past/Present Alcohol or Drug Use (specify drug or any other addiction/dependence, usage, duration):

____

Family History (of alcoholism, chemical dependence, mental illness, violence, suicide):

____

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Presenting Problem(s):

_____

_____

_____

Client Strengths:

_____

_____

_____

Client Obstacles:

_____

_____

_____

Client Goals:

_____

_____

_____