

Roberto Olivo
Licensed Marriage and Family Therapist

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INTAKE

NAME (1ST PERSON) _____ Birth Date _____

NAME (2ND PERSON) _____ Birth Date _____

Address _____

Cell Phone # _____ Work Phone # _____

Can we leave voice message to your cell phone? _____ Yes or _____ No

Email address: _____

Can we send you emails to this address? _____ Yes or _____ No

Emergency Contact _____ Phone# _____

Relationship to you _____

What is your relationship status? (Dating, living together, engaged, married,
separated, divorced?) _____

Do you have any children? (List names, ages, gender, and percentage of custody)

Reason for seeking counseling sessions?

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Do you have any current medical conditions? In the past? Any Medications? Side Effects?

1st Person _____

2nd Person _____

Do you currently smoke cigarettes, marijuana, or take non-prescription drugs (or in the past)? How much and for how long?

1st Person _____

2nd Person _____

How much alcohol do you drink?

1st Person _____

2nd Person _____

Have you ever been in psychotherapy? 1st Person _____, 2nd Person _____

Are you currently in therapy? If so, with whom?

1st Person _____

2nd Person _____

THANK YOU!

1st Person's Signature _____ Date _____

2nd Person's Signature _____ Date _____