Maren Martin, LCSW
Licensed Clinical Social Worker
License # LCS 19351

Date:_____

Name:_____ DOB:_____ Age:_____

Address:_____

Phone(s):_____ Gender _____

Relationship Status:_____ Partner's Name:_____

Length of Rela._____ Dates of separation or divorce (if applicable):_____

Children	Age	Custody?	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employed by:_____ Position:_____

Referred by:_____ Relationship:_____

Previous Psychotherapy?_____ Therapist(s):_____
How long?_____

Physician's Name:_____ Phone:_____

Currently under Medical Treatment?_____ For:_____

All Medications That You Take: _____

_____

Major Illness and Injuries:_____ Date:_____

_____ _____

_____ _____

207 16th Street #305 Pacific Grove, CA 93950
(831) 375-1134

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Please check any of the following that apply to you now or have applied in the past:

	past	present		past	present
Headaches	____	____	Unable to relax	____	____
Eating issues	____	____	Psychiatric hospitalization	____	____
Anxiety	____	____	Sexual difficulties	____	____
Depression	____	____	Frequently tired	____	____
Suicidal thoughts	____	____	Poor appetite	____	____
Chronic pain	____	____	Recreational drug use	____	____
Alcohol use	____	____	Physical abuse	____	____
Sleeping problems	____	____	Sexual abuse	____	____
Nicotine use	____	____	Suicide attempt(s)	____	____
			Dates: _____		

Stress: How would you rate your typical stress level (0-10)? _____ Current level? _____

Your reasons for seeking therapy: _____

_____

_____

Any additional information that you'd like me to know: _____

_____

_____

In Case of Emergency Notify:_____ Phone:_____

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