

Lisa A. Maurel, M.F.T.  
1400 Bristol Street North, Suite 250  
Newport Beach, CA 92660  
714.390.8189

**Please complete the information below. All information is CONFIDENTIAL.**

**Client Information Packet:**

**Pages 1-2 Client Information - Please Complete**

**Pages 3-4 Policies and Consent -Please Read and Sign**

**Page 5 Therapy Partner Account Set Up-Please Complete**

Today's Date \_\_\_\_\_

Referred By \_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Sexual Orientation: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_,  
State \_\_\_\_\_, Zip \_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Job Satisfaction: High to Low: \_\_\_\_\_

Years employed with this company: \_\_\_\_\_ Years in Self Employment: \_\_\_\_\_

Education Obtained: \_\_\_\_\_

**Reason for Consultation**

Briefly describe your reason for seeking my services at this time. \_\_\_\_\_  
\_\_\_\_\_

What would you most like to address in our work together? \_\_\_\_\_  
\_\_\_\_\_

Have you been in therapy before? If so, please describe the reason for therapy at that time and whether you felt positively about your experience.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Relationship Information**

Are you single? \_\_\_\_\_ Married/Partnered? \_\_\_\_\_ If so, number of years \_\_\_\_\_ Separated/Divorced? \_\_\_\_\_  
If so, for how long? \_\_\_\_\_

Name of Spouse/Partner: \_\_\_\_\_

Names & ages of Children: \_\_\_\_\_

Are you presently involved in any custody disputes? Yes\_\_ No\_\_  
Are you presently involved in any legal disputes /lawsuits/divorce/custody/workers comp? Yes\_\_ No\_\_

**Health History**

Do you have any major illnesses or disabilities? \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Have you seen a psychiatrist in the past five years? \_\_\_\_\_

Doctor's Name/Phone: \_\_\_\_\_

What medications do you currently take? \_\_\_\_\_

Circle your answer:

Do you smoke? Yes no  
Drink alcohol? Never Monthly Weekly More than 3 days a week Daily  
Drugs? Never Monthly Weekly More than 3 days a week

Have you ever been hospitalized for treatment of a psychological condition or substance abuse problem? Yes  
No If so, briefly describe the outcome and treatment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History**

Are you adopted? YES NO If yes, please indicate your age, placements and any contact you have had with bio. parent?

\_\_\_\_\_  
\_\_\_\_\_

Did you grow up with your biological parents? YES NO If no, please describe your living situation:

\_\_\_\_\_

Were there any major separations from your parents or traumatic events that you identify such as divorce; illness, hospitalization of parent or sibling; marital separations; moves etc.

\_\_\_\_\_  
\_\_\_\_\_

Give a brief description of your relationships with the following persons and note any significant health/psychological history such as alcoholism, depression, anxiety, suicide attempt etc.

Mother \_\_\_\_\_ Father \_\_\_\_\_

StepFather: \_\_\_\_\_ StepMother: \_\_\_\_\_

Sibling \_\_\_\_\_ Sibling \_\_\_\_\_

Spouse/Partner \_\_\_\_\_ Ex Spouse/Partner \_\_\_\_\_

Child \_\_\_\_\_ Child \_\_\_\_\_

Additionally, I would like you to know.....

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