

LOUISE JACOBUS, MA, LMFT

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Name _____ Date _____
Address _____ Date of Birth _____
_____ zip _____ Age _____
Email _____ Referred by _____

Phones:

Is it ok to leave a confidential voice message for you at this number?

home _____ yes/no

cell _____ yes/no

work _____ yes/no

Occupation/ Employer _____

Marital/ Relationship status _____

Emergency Contact(s)

Name _____ Relationship _____

Address _____ zip _____

cell _____

work and/or home _____

Please list all family members:

I. Spouse or primary relationship. Children.

Anyone else living in your home.

Name	Relationship to you	Age	Occupation
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

II. Parents, brothers, sisters

Name	Relationship to you	Age	Occupation

Where did you grow up? _____

Education, Technical Training _____

Current medications you are taking _____

Primary Physician _____

Previous counseling or therapy. Previous hospitalizations or treatment programs _____