

Gail D. Gerbie, MS, LMFT
Marriage & Family Therapist MFC 53709
27715 Mountain Meadow Rd. #37 Escondido, CA 92026
760-995-2006 gail.gerbie@gmail.com

Date: _____

Name: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Text OK? YES NO

Email: _____ Other: _____

Please circle preferred contact method

Marital Status: Single Married Separated Divorced Widowed Live-In Partners

Birthdate: _____

Employer:

Company	Location	Phone/email
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Emergency Contact:

Name	Address:
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Phone#	Mobile #	Relationship
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Referred by: _____

INTEREST IN COUNSELING

Primary reason(s) for seeking therapy: _____

Why now? _____

Have you ever seen a therapist in the past? YES NO

Are you currently seeing another mental health provider? YES NO

If so,
Name: _____ Title: _____

Purpose: _____

Are you currently taking any prescription mind or mood medications? Yes No

Antidepressants Anti-Anxiety Meds Sleep Aids Hormone Replacements Pain Meds Other

If you know the name/dosage of the medication, please list.