LEHMAN THERAPY
JULIE LEHMAN, MS, LMFT #109200

CLIENT INTAKE FORM

1. Full Name: ____________________________________
2. Preferred Name: ____________________________________
3. Preferred Pronouns: ____________________________________
4. Date of Birth: ____________________________________
5. Address: ____________________________________
   ____
6. Phone Numbers: ____________________________________
   ____
7. Email: ____________________________________
8. Preferred Contact Method: ____________________________________
9. Emergency Contact: (name) ____________________________________
   (phone) ____________________________________
   (address)____________________________________
   ____

The following questions are optional. Please use this page to provide background information for your treatment only if it is comfortable to do so.

10. Current and past psychological issues/diagnoses

11. Current and/or past medical conditions

12. Current and/or past substance use

13. Anything else you feel is important for me to know about you or your health