



Risa L. Davis-Ganel, LCMFT
Licensed Clinical Marriage and Family Therapist

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RisaGanel.com

Client Intake Information

General Information

Today's Date _____

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: (Name, Relationship, telephone): _____

- **What challenges are you seeking help for?** (e.g., depression, anxiety, marital problems etc.)

- **Have you ever been in therapy before?** ____ Yes ____ No

If you answered "yes", please briefly describe the situation (e.g., when, where, with whom):

- **Family Information** (Spouse, all children and any others who live in your household):

| Name | Age | Relationship |
|------|-----|--------------|
| | | |
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| | | |
| | | |
| | | |

- **Medical**

Please list all current medications: _____

• Primary Care Physician: _____ Address: _____ Phone: _____

• Other Mental Health Provider: _____ Address: _____ Phone: _____

Please read the "Informed Consent" and "General Policies" documents before signing below.

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). I affirm that prior to becoming a client of Risa L. Davis-Ganel, LCMFT, she gave me sufficient information to understand the nature of therapy, including the possible risks and benefits. I understand her office policies and procedures. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment at any time.

Signature

Date

Signature

Date