Kimberly Warner-Getskow, LMFT
*Licensed Marriage and Family Therapist*
*CA License No. LMFT92540*
*(661) 367-1006*

# *Patient Information*

**Date** ____________________

***Name*** ______________________________________________ **Home Phone** ____________________

**Address** ______________________________________________ **Work Phone** ____________________

______________________________________________ **Cell Phone** ____________________

**Email** ______________________________________________ **SSN** ____________________

**Age** _________ **DOB:** ______________________________ **Occupation** ____________________

### *Emergency Contact Information:*

**Name** ______________________________________________

**Phone** ______________________________________________

**Relationship** ___________________________________________

### *Financial Information:*

**How do you intend to pay for treatment?**

**(Cash, check, charge, insurance)** _______________________________________________________

***If planning on using health insurance:***
**Name of Insurance Company**

_________________________________________________________________

**Policy Number** ________________________________________ **Group No.** ____________________

**Phone** _______________________________

### *Areas of Concern*

**What issues/concerns cause you to seek treatment? Please describe** _____________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Do you have any specific goals with regard to your treatment?** ___________________________________

______________________________________________________________________________________

______________________________________________________________________________________

**Do you have any particular concerns/fears with regard to your treatment?** ________________________

______________________________________________________________________________________