Patient Information (Please fill out prior to first appointment)

**LISA FRIEDMAN, MA, LMFT**

Date:_____

Name_____

Address:_____

_____

Age:_____DOB_____

Social Security No_____

Phone # Home_____ Cell_____

Occupation_____Empoyer_____

Marital status:_____

Sexual orientation_____

Name of Spouce_____Age_____

Names and ages of children_____

_____

Referred by:_____

Other therapy

experiences_____

_____

Emergency Contact Information:

Name_____

Phone Number_____