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### CLIENT INFORMATION

Today's Date: \_\_\_\_\_

Client(s) Name(s): \_\_\_\_\_

Birthdate(s): \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Birthdate \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

May I use my name if I phone your work? \_\_\_ Yes \_\_\_ No

May I use my name if I phone your home? \_\_\_ Yes \_\_\_ No

Email Address: \_\_\_\_\_

Do you check email daily? \_\_\_ Yes \_\_\_ No

May I use email to communicate with you? \_\_\_ Yes \_\_\_ No

Occupation(s): \_\_\_\_\_

Employed by: \_\_\_\_\_

Marital Status:

\_\_\_ Single \_\_\_ Married \_\_\_ Partnered \_\_\_ Divorced

\_\_\_ Widowed \_\_\_ Separated

Length of relationship (if applicable) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Describe any medical issues that may be of concern:

List any medications you are currently taking:

Have you had any previous therapy /counseling experiences? \_\_\_ Yes \_\_\_ No

If so, please describe type and length of therapy:

Please use this space for any additional information you feel is valuable for me to know.