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Adult Intake form

Date: _____

Name/s: _____

Birth Date/s: _____ Age/s: _____

Address: _____ City: _____ Zip: _____

Best phone no. to reach you on? Cell(s) () _____ / _____ Home () _____

May I say who I am if I phone your home? Yes ___ No ___ Email: _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Separated ___

Length of time and name of spouse: _____

Do you have children? ___ Children's ages:/Names _____

Have you had previous Therapy/Counseling? Yes ___ No ___

Type of Therapy/Counseling: Family: ___ Individual: ___ Group: ___ Couple: ___

Referred by: Self: _____ Dr.: _____ Other: _____

Primary reason for seeking therapy: _____

Do the primary problems include any of the following? (Please check all that apply):

Custody Issues: _____

Workers Compensation: _____

Seeking treatment as a requirement of probation: _____

Personnel issues or work related problems: _____

Seeking evaluation or testing for legal or other reason: _____

Victim of a violent crime: _____

Parent/child problem: _____