CLIENT DATA SHEET

CYNTHIA WESTON, L.M.F.T.

2660 Townsgate Rd., Ste. 530 Westlake Village, CA 91361 (818) 347-2600 License # MFT42043

Date of Birth:	Client	
Age:	Name:	
Marital Status:	Age:	
Address: City,State,Zip: Home Phone: Cell Phone: Place of Business: Business Phone: Name and ages of Children: Name of Person to Contact in Case of Emergency: Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes Therapist Amount of Time: Psychiatric Hospitalizations NoYes Hospital: Amount of Time:	Date of Birth:	
City,State,Zip:	Marital Status:	
Home Phone: Cell Phone: Place of Business: Business Phone: Name and ages of Children: Name of Person to Contact in Case of Emergency: Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes Therapist Amount of Time: Psychiatric Hospitalizations NoYes Hospital: Amount of Time: Amount of Time: Amount of Time: Amount of	Address:	
Home Phone: Cell Phone: Place of Business: Business Phone: Name and ages of Children: Name of Person to Contact in Case of Emergency: Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes Therapist Amount of Time: Psychiatric Hospitalizations NoYes Hospital: Amount of Time: Amount of Time: Amount of Time: Amount of	City,State,Zip:	
Cell Phone:		
Place of Business: Business Phone: Name and ages of Children: Name of Person to Contact in Case of Emergency: Phone: Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:Amount of Time:Amount of Time:Amount of		
Business Phone:Name and ages of Children:Name of Person to Contact in Case of Emergency:Phone:	Place of Business:	
Name and ages of Children: Name of Person to Contact in Case of Emergency: Phone: Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes Therapist Amount of Time: Psychiatric Hospitalizations NoYes Hospital: Amount of Time: Amount of Time: Amount of		
Name of Person to Contact in Case of Emergency:	Name and ages of	
Name of Person to Contact in Case of Emergency:	Children:	
Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences:NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:		
Phone: Relationship: Serious Illnesses, Accidents, Operations, Medical Conditions: What Brings you Here At This Time: Previous Therapy Experiences:NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:	Emergency:	
Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital: Amount of Time: Amount of		
Conditions: What Brings you Here At This Time: Previous Therapy Experiences: NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital: Amount of Time: Amount of		
What Brings you Here At This Time: Previous Therapy Experiences:NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:	Serious Illnesses, Accidents, Operations, Medical	
Time: NoYes Previous Therapy Experiences:NoYes Therapist Amount of Time: Psychiatric HospitalizationsNoYes Hospital: Amount of Time:	Conditions:	
Time: NoYes Previous Therapy Experiences:NoYes Therapist Amount of Time: Psychiatric HospitalizationsNoYes Hospital: Amount of Time:		
Time: NoYes Previous Therapy Experiences:NoYes Therapist Amount of Time: Psychiatric HospitalizationsNoYes Hospital: Amount of Time:	What Brings you Here At This	
Previous Therapy Experiences:NoYes TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:		
TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:		
TherapistAmount of Time: Psychiatric HospitalizationsNoYes Hospital:Amount of Time:	Provious Thorany Experiences: No. Ves	
Time: NoYes Hospital: Amount of Time:	17 1	mount of
Psychiatric HospitalizationsNoYes Hospital:Amount of Time:	-	mount of
Hospital:Amount of Time:		
Time:	· ·	f
	-	-
Family or Significant Other(s) Psychiatric Hospitalization:NoYes		o Yes

CLIENT DATA SHEET

Hospital:					Amount of
Time			_		
Use of Alcohol:					
(if yes) Times Per:		_Day _		Week	
Type:	Amo	ount:			
Use of Drugs:	_No _		_Yes		
(if yes) Times Per:		_Day _		Week	Туре:
Amount:					
Eating Disorder:	No _		Yes		
(if yes) Type					<u>_</u>
For How Long					<u> </u>
History of Sexual Abuse					
sexual intrusion	mol	lestatio	n	_rape	sexual harassment
other					
Physical Abuse:	_No _		_Yes		
(if yes) Type					
For How Long					
Gambling, Shopping, oth	er Ado	dictions	s:	No	Yes
(if yes) Type					
For How Long					
Suicidal History:					
(if yes)					
Explain					
Additional					
Information:					
Referred					
Ву:					
БУ					
Signature of Client:					Date
Signature of Parent:					Date:
	(if ci	lient is i	a minor	·)	