Lydia Mendoza, LCSW
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Name_____________________________________________ Date of Birth_______________

Address ____________________________________________________________________

City ________________________________ Zip ________ Occupation __________________

Phone: W: ____________________ H:____________________ M:____________________

In case of emergency _______________________________ Phone ______________________

Referred by EAP: Y_____N_____

Have you ever been to therapy before? If so, when and what was addressed.

Current health conditions:

Current medications:

What is motivating you to seek therapy this time?

________________________________________ ____________________

Client Signature Date