Rosa Lutrario

Psychotherapist

LCSW# 68921

(510) 903-2020

329 A 14th Street

Oakland, CA 94612

Client Information Form Date: _____

Legal Name:

_____

DOB: _____

Preferred Name (if applicable): _____

Preferred Pronoun (if applicable): _____

Address:

_____
_____
___

Mobile phone: _____Other phone:_____

May I leave a message? Y/N

Occupation: _____

Education level:_____

How do you racially/ethnically identify?_____

Reason(s) for seeking therapy and what do you want to gain from engaging in therapy:

_____
_____
_____
_____
_____

Past/Current mental health and/or substance abuse diagnoses: (If applicable)

_____
_____
___

Current medications:_____
_

Are you currently experiencing feelings of hopelessness and/or having suicidal thoughts? Y/N
If yes, please describe_____
_____
_____
_____
_____

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Relationship status: _____ Do you have children? Y/N _____
If yes, children name(s)/age(s):
_____
_____

Emergency contact name: _____ Relationship: _____
Emergency contact phone: _____

How were you referred to me? (Please circle or fill in):

Internet/website: _____
Friend/Relative: _____
Another therapist/provider: _____

Is there anything else you would like for me to know at this time?
_____
_____
_____
_____
_____
_____