

**Sabine Boots, M.S., LMFT**

Licensed Marriage & Family Therapist; Nutrition & Wellness Consultant

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**Client Information**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Pers. Pronouns \_\_\_/\_\_\_

Profession: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse/Partner (if applicable): \_\_\_\_\_ DOB: \_\_\_\_\_ Pers. Pronouns \_\_\_/\_\_\_

Profession: \_\_\_\_\_

Children's names (if applicable): \_\_\_\_\_ DOB: \_\_\_\_\_ School Grade: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_ School Grade: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_ School Grade: \_\_\_\_\_

Mailing address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Is it OK to contact you via e-mail? Please initial: Yes \_\_\_\_\_, No \_\_\_\_\_

(due to the nature of the Internet safeguarding of information cannot be guaranteed by the therapist)

Phone number(s) I can best reach you at: \_\_\_\_\_

Referring physician/or other source: \_\_\_\_\_

If you are referred by an other health care professional, do you allow me to acknowledge receiving the referral? Please initial: Yes \_\_\_\_\_, No: \_\_\_\_\_

Previous experience with therapy? \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_

Is there a history of depression and or suicide in your family? If yes, please explain

\_\_\_\_\_  
\_\_\_\_\_

Please, answer following questions using the numbers 1-5:

1=never, 2=rarely, 3=sometimes, 4=frequently, 5=almost always (feel free to leave empty if doesn't apply)

- 1. I am stressed at work/school. \_\_\_\_\_
- 2. I blame myself for things. \_\_\_\_\_
- 3. I feel unhappy in my marriage/significant relationship. \_\_\_\_\_
- 4. I'm unhappy about my sex life \_\_\_\_\_
- 5. I am worried about my family. \_\_\_\_\_
- 6. I feel lonely. \_\_\_\_\_
- 7. I experience a lack of concentration. \_\_\_\_\_
- 8. I feel hopeless about the future. \_\_\_\_\_
- 9. I cannot get rid of disturbing thoughts in my mind. \_\_\_\_\_
- 10. I experience sleep problems. \_\_\_\_\_
- 11. I have headaches or stomach aches. \_\_\_\_\_
- 12. I have problems with my eating behaviors. \_\_\_\_\_
- 13. I am worried about my consumption of alcohol/or other substances. \_\_\_\_\_
- 14. I experience anxiety. \_\_\_\_\_
- 15. I feel the need for better anger management skills. \_\_\_\_\_