

**CARL MOJTA, LMFT, LLC**  
**Licensed Marriage & Family Therapist (DC#: LMFT000169)**  
**Licensed Marriage & Family Therapist (VA#: 0717001428)**  
**Certified Addiction Counselor I (DC#: CACI1137)**

**PLEASE PRINT NEATLY**  
**Couples and Families: Each person needs to complete this form.**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell: \_\_\_\_\_ (May I leave a voice message on this number?) \_\_Yes\_\_ No

Home: \_\_\_\_\_ (May I leave a voice message on this number?) \_\_Yes\_\_ No

**Email:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**How did you hear about me?** \_\_\_\_\_

*If by an internet search, what key word(s) did you use?* \_\_\_\_\_

**If you are in a current relationship, on a scale of 1 -10 (10 being the best), how would you rate your relationship?** \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_

Phone number \_\_\_\_\_

Relationship to you \_\_\_\_\_

**Are you currently seeing another therapist or psychiatrist?** Yes \_\_\_\_\_ No \_\_\_\_\_

Name(s) \_\_\_\_\_

*If yes, please complete a Release of Information form and we will discuss if it would be helpful to coordinate treatment.*

MEDICATION	PURPOSE	PRESCRIBED BY WHOM

