



# Gary Lange, Ph.D.

Licensed Marriage and Family Therapist #25633  
Certified Addictions Specialist and Gambling Counselor  
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## INTAKE FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

OTHER PHONES: WORK/OFF.: \_\_\_\_\_ CEL \_\_\_\_\_

D.O.B.: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ MALE/FEMALE: \_\_\_ Referral By: \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION/POSITION: \_\_\_\_\_

PERSON AND NO. TO CALL IN EMERGENCY: \_\_\_\_\_ NO \_\_\_\_\_

Family: SPOUSE/PARTNER'S NAME: \_\_\_\_\_ AGE: \_\_\_ Years: \_\_\_ OCCUPATION: \_\_\_\_\_

CHILDREN/STEP/GRAND (names/ages) \_\_\_\_\_

LIVING PARENTS/STEP-PARENT(s) (Ages/Hometown): \_\_\_\_\_

SIBLINGS (names/ages/Supportive?): \_\_\_\_\_  
(Circle those living with you)

I AM HERE BECAUSE: \_\_\_\_\_

HOBBIES/SUPPORT SYSTEM \_\_\_\_\_

MEDICAL DOCTORS: \_\_\_\_\_ PHONE: \_\_\_\_\_ LAST EXAM: \_\_\_\_\_

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations: \_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

PAST/PRESENT COUNSELING/PSYCHOTHERAPY: \_\_\_\_\_

Amount: CAFFEINE? \_\_\_/DAY; TOBACCO? \_\_\_/DAY; ALCOHOL? \_\_\_/WEEK; OTHER DRUGS? \_\_\_/WEEK

Family History of Addiction, Mental Illness, Violence, Suicide: \_\_\_\_\_

Ever lied about your gambling? Yes or No Have you ever bet more than you intended? Yes or No

Circle if you have had a change in any of these in the past 6 months: weight; sleep/concentration/memory problems, anxiety, depression, alcohol, drug, gambling, anger, sexual activity, general level of activity, other \_\_\_\_\_

*Use the space below or on the back of this form if you need to give further information*