



**LMFT**  
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Today's date: \_\_\_\_\_

**Note:** If you have been a client here before, please fill in only the information that has changed.

**A. Identification**

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Nicknames or aliases: \_\_\_\_\_  
Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Best Number to Reach You: \_\_\_\_\_ e-mail: \_\_\_\_\_  
Is it okay to leave a message on your voice mail or on email?  Yes  No

**B. Referral:** Who gave you my name to call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

**C. Religious and racial/ethnic identification**

Current religious denomination/affiliation  Protestant  Catholic  Jewish  Islamic  Buddhist  Hindu

Other (specify): \_\_\_\_\_

Involvement:  None  Some/irregular  Active

How important are spiritual concerns in your life? \_\_\_\_\_

Ethnicity/national origin: \_\_\_\_\_ Race: \_\_\_\_\_ or other similar way  
you identify yourself and consider important: \_\_\_\_\_

**D. Your medical care:** From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

**E. Your current employer**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**F. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

**G. Your education and training**

Are you currently a student Y N Fulltime \_\_\_ Parttime \_\_\_ Grade/Level \_\_\_\_\_ Expected Grad. Date \_\_\_\_\_

Last Grade Completed \_\_\_\_\_ High School Y N College: Y N Graduate School: Y N

Last or Current School \_\_\_\_\_ Location \_\_\_\_\_

**H. Military experience ?** Y \_\_\_ N \_\_\_ Enlistment Dates: From: \_\_\_\_\_ to \_\_\_\_\_

**I. Family-of-origin history**

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased)
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Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sisters \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Stepmother \_\_\_\_\_

Stepfather \_\_\_\_\_

Grandparents \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Others \_\_\_\_\_

\_\_\_\_\_

**J. Marital/Relationship history**

Single  In a Relationship  Married  Separated  Divorced  Widowed  Remarried

Name of Significant other \_\_\_\_\_ Age \_\_\_\_\_

Date Relationship Began \_\_\_\_\_ Date of Marriage \_\_\_\_\_

Date of Separation/Divorce/Death/ Relationship End \_\_\_\_\_

If divorced, has ex-spouse remarried? \_\_\_\_\_

**K. Children** Indicate those from a previous marriage or relationship with "P" in the last column.

Name	Current age	Sex	School	Grade
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				
_____				

**L. Chief concern**

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_

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

**M. Treatment**

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

No  Yes If yes, please indicate:

1.Name of provider: \_\_\_\_\_

Address of provider: \_\_\_\_\_

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

Dates of Service \_\_\_\_\_

Can I contact this provider to better coordinate care? Y\_\_\_\_\_ N\_\_\_\_\_

2.Name of provider: \_\_\_\_\_

Address of provider: \_\_\_\_\_

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

Dates of Service \_\_\_\_\_

Can I contact this provider to better coordinate care? Y\_\_\_\_\_ N\_\_\_\_\_

**N. Medications**

Name	Dose	Purpose	Date From	Side Effects/Concerns

**O. Relationships in your family of origin.**

Please describe the following:

1. Your parents' relationship with each other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Your relationship with each parent and with any other adults present: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Your relationship with your brothers and sisters, in the past and present: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

P. History of Abuse ? \_\_\_\_Y \_\_\_\_N     Physical     Sexual     Emotional     Verbal     Neglect

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Q. Chemical use**

- 1. How many cups of regular coffee do you drink each day? \_\_\_\_\_ How many cups of tea? \_\_\_\_\_.  
How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? \_\_\_\_\_  
How many "energy drinks"? \_\_\_\_\_ How often do you use No Doz or similar caffeine pills? \_\_\_\_\_.
  - 2. How much tobacco do you smoke or chew each week? \_\_\_\_\_
  - 3. Have you ever felt the need to cut down on your drinking?  No  Yes
  - 4. Have you ever felt annoyed by criticism of your drinking?  No  Yes
  - 5. Have you ever felt guilty about your drinking?  No  Yes
  - 6. Have you ever taken a morning "eye-opener"?  No  Yes
  - 7. How much beer,wine,or hard liquor do you consume each week,on the average? \_\_\_\_\_
  - 8. Are there times when you drink to unconsciousness,or run out of money as a result of drinking?  No  Yes
  - 9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner?  No  Yes If yes, which and when? \_\_\_\_\_
- Which drugs (not medications prescribed for you) have you used in the last 10 years? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Please provide details about your use of these drugs or other chemicals,such as amounts,how often you used them, their effects,and so forth: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**R. Legal history**

- 1. Are you presently suing anyone or thinking of suing anyone?  No  Yes. If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 2. Is your reason for coming to see me related to an accident or injury?  No  Yes If yes,please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- 3. Are you required by a court, the police, or a probation/parole officer to have this appointment?  No  Yes. If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**S. Other**

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: \_\_\_\_\_

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