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LMFT#100342

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 CurrentSchool_____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)

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: _____

_____

_____

_____

_____

_____

_____