KATHERINE JEWETT LMFT

Licensed Marriage and Family Therapist

Thriving, not just surviving your life.

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Today's date: _____

A. Identification

Client's Name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone: _____ e-mail: _____

Is it okay to leave a message on 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 Client's 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. 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: _____

F. Education

Current School	Grade	Teacher	Years Attended

G. Family-of-origin history

Relative	Name	Current age (or age at death)	Illnesses (or cause of death, if deceased) including depression, anxiety, bipolar, ADHD etc.
Father			
Mother			
Brothers			
Sisters			

Stepmother _____ _____ _____

Stepfather _____ _____ _____

Grandparents_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

H. Relationships in Client's family of origin.

Please describe the following:

1. Client's parents' relationship with each other: _____

_____

_____

_____

2. Client's relationship with each parent and with any other adults present: _____

_____

_____

_____

3. Parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____

_____

_____

_____

4. Client's relationship with your brothers and sisters in the past and present: _____

_____

_____

_____

I. History of Abuse ? _____Y ___N ☐ **Physical** ☐ **Sexual** ☐ **Emotional** ☐ **Verbal** ☐ **Neglect**

Explain:_____

_____

_____

_____

J. Chief concern

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

_____

_____

_____

K. Treatment

1. Has your child 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_____

L. Medications

Name	Dose	Purpose	Date From	Side Effects/Concerns

M. Chemical use

Please indicate which of the following Client uses or has used:

	Current Amount/week	Past Amount/week and when
☐ Coffee	_____	_____
☐ Tea	_____	_____
☐ Soda	_____	_____
☐ Energy Drink	_____	_____
☐ Alcohol	_____	_____
☐ Tobacco	_____	_____
☐ Marijuana	_____	_____
☐ Other:_____		

Please provide details aboutabove chemical use, including how often used them, their effects and so forth:

_____

_____

_____

N. Other

Is there anything else that is important for me as a 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: _____

_____

_____

_____

_____

_____

_____