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LICENSE NO. LMFT52602
LICENSED MARRIAGE AND FAMILY THERAPIST
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Today's Date: _____/_____/_____

ABOUT YOU (THE CLIENT): The client this pertains to is: ***An Adult*** ***A Minor***

Your name:_____ Date of Birth:_____/_____/_____ Age:_____

Home Street Address: _____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell:_____

Number you prefer to be contacted:_____ May I call you at work? **Yes** **No**

Best time to reach you at your preferred number:_____

May I contact you via email: **Yes** **No** (You may opt out at anytime; your address is not sold or shared with anyone.)

Email Address: _____

Are you being seen **with** a partner as a **couple**? **Yes** **No**

YOU AND YOUR PARTNER:

Partner's Name:_____ Date of Birth:____/____/_____ Age: _____

Home Street Address: _____ Apt#_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ Cell:_____

Preferred contact number:_____ May I call him/ her at work? **Yes** **No**

Best times to reach him/ her at the preferred number: _____

Are you married? **Yes** **No** Married or not, how long have you been together?_____

Are you divorced/ separated? **Yes** **No** If yes, for how long? _____

Have you ever been separated from your current partner? **Yes** **No** If yes, how long? _____ When_____

PERSON TO CALL IN CASE OF EMERGENCY:

Name:_____ Phone:_____

Relation:_____

REFERRAL: How did you hear about my practice? (Circle as many that apply)

Friend On the Internet My Insurance Co. EAP Provider Other_____

If a friend referred you, how did this person explain how I might be of help to you?

_____

If on the Internet, which site?_____

YOUR MEDICAL CARE:

Doctor's Name: _____ Phone:_____

Address: _____

Date of your last medical exam: _____/_____/_____

If necessary, may I inform your doctor that you are in treatment with me so that he/she can be fully informed and coordinate your care? **Yes No**

MEDICAL HISTORY:

Please describe any present or past major medical problems (e.g., major illness, surgeries, accidents, etc.):

_____

_____

_____

MEDICATIONS:

Are you currently taking any psychotropic medications? (e.g., anti-depressants/ anti-anxiety medications) **Yes No**

If yes, What is prescribed? _____ Dosages:_____

Who is the prescriber? **Psychiatrist** or **Primary Care Physician**

Are you presently taking any medications for physical (non psychiatric) problems? **Yes No**

If yes, What is prescribed?_____ Dosages:_____

Any regular use of over the counter medications? _____

ALCOHOL AND SUBSTANCE USE:

How often do you drink an alcoholic beverage?

Never Monthly 2-4 times a month 2-3 times a week More than 4 times a week

On a day you do drink, how many alcoholic beverages might you have?

1 to 2 3 to 4 5 to 6 More than 6 More than 10

In the past year, what is the greatest number of drinks you had on any one occasion?

1 to 2 3 to 4 5 to 6 More than 6 More than 10

Have you ever wanted to stop drinking? **Yes No** If yes, have you and for how long?_____

Have loved ones expressed concern about your drinking? **Yes No** If yes, who?_____

Have you ever had any legal problems due to your drinking (DUI, public intoxication)? **Yes No**
If yes when?_____

Have you ever had treatment for your drinking? **Yes No**

If yes, what kind? **Inpatient Outpatient 12 Step**

Are you currently using any street drugs (Marijuana, Cocaine, Methamphetamine, Heroin, etc.)? **Yes No**

What drug(s) are you currently using?_____

How often?_____ How long have you used?_____

Have you ever wanted to stop using? **Yes No** If yes, have you, and for how long? _____

YOUR EDUCATION/ OCCUPATION:

Highest grade:_____ Degree:_____

Employer:_____ Position:_____

PRIOR THERAPY:

Have you seen a Therapist before? **Yes No** Have you been in therapy more than once? **Yes No**

If yes to either, when? _____ For how long? _____

Reason(s) you sought therapy before:_____

Is this the same reason(s) you are coming to see me today? **Yes No**

Were you satisfied with the outcome of your previous therapy? **Yes** **No**

If yes, why?_____

If no, why not? _____

YOUR SIGNIFICANT RELATIONSHIPS:

Do you have children? **Yes** **No** If yes, indicate below: (use back or additional sheet, if necessary)

Name:_____ Gender: _____ Age: _____

Name:_____ Gender: _____ Age: _____

Name:_____ Gender: _____ Age: _____

Name:_____ Gender: _____ Age: _____

Are there other family members living with you (elderly parents, siblings, etc)?

Name: _____Gender: _____ Age: _____ Relation: _____

Name: _____Gender: _____ Age: _____ Relation: _____

Name: _____Gender: _____ Age: _____ Relation: _____

Briefly describe how you get along with your partner or spouse: _____

_____

What do you MOST appreciate about your partner?_____

What your partner MOST appreciates about you:_____

Major life stressors (financial, employment, etc.) facing you, your partner and/ or family? **Yes** **No**

If yes, briefly describe:_____

YOUR FAMILY OF ORIGIN:

Are your parents still together? **Yes** **No** If yes, how long? _____

Briefly describe the reason your parents are no longer together: _____

Do you have brothers and/ or sisters? **Yes** **No**

Beginning with your oldest sibling (even if that's you), list their names and current ages: _____

_____

If your parent(s) are still living, briefly characterize your current relationship with each of them: _____

_____

Is there a history of drug or alcohol abuse in your family of origin? **Yes** **No** if yes, who? _____

YOUR CHIEF CONCERN:

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

_____

_____

Estimate the severity of the problem: **Mild** **Moderate** **Severe** **Very Severe**

YOUR GOALS:

What would you MOST like to see happen in your life as a result of coming to see me?_____

_____

_____

What do you MOST want to change about yourself? _____

_____

What do you think or feel is the greatest barrier to creating change in your life right now? _____

_____

AND FINALLY……

Tell me anything more you would like me to know about you and/or the reason you have come to see me today that you think would be essential that I know: _____

_____

_____

Please bring your completed forms to your first session.

Thank you!!