Teri Tingey M.S., LMFT
Licensed Marriage and Family Therapist
3655 Alamo St. Suite 202 Simi Valley CA 93063
Phone (805) 907-2316

Date: _____

Referred by: _____

Name_____ Age_____ Date of Birth_____
Address: _____ City: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Do I have permission to call you on your cell phone (circle) Yes or No
Do I have permission to text you on your cell phone (circle) Yes or No

Occupation: _____ Place of Employment: _____ Full/Part Time (circle)

Present Marital Status: ☐Married ☐ Divorced ☐Separated ☐Widowed
☐Domestic Partnership ☐ Never Married ☐Remarried

Name of Spouse or Significant other: _____Years in the relationship _____

Children or Stepchildren (indicate by C or S)

Name of Child: _____ Age: _____ Area of Concern: _____

Name of Child: _____ Age: _____ Area of Concern: _____

Name of Child: _____ Age: _____ Area of Concern: _____

Others in Household: _____

Whom were you raised by: Both Parents _____ Single Parent(s) _____ Relative _____ Other _____

Briefly describe your relationship with primary care giver(s) _____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate family member's relationship to you in the space provided (father, grandmother, uncle etc.).

	Please Circle	
Alcohol/Substance	Yes/No	_____
Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Bipolar Disorder	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Suicide Attempts	Yes/No	_____

Religious orientation/affiliation: _____

Personal

Any history of serious illness? (yes/no)_____
Any serious injuries or operations? (yes/no)_____
Any significant loss in your life? _____

Current Medications being taken:

Medication and Dosage	Prescribed for	Prescribed & Supervised by
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Drink? (Circle) Yes/No Do you smoke? (Circle) Yes/No

Do you participate in regular exercise? If so, how often do you exercise? (Circle) Yes/No
Describe: _____

Previous Therapy ☐ Individual ☐ Couple ☐ Family ☐ Group ☐ Inpatient
☐ Outpatient ☐ Psychiatrist

Previous Therapist/Practitioner _____

What do you consider some of your strengths? _____

_____

What do you enjoy doing during your leisure time? _____

_____

Current Concerns:

_____

_____

_____

Goals of Treatment:

_____

_____

_____

Check boxes that are currently relevant:

- ☐ Traumatic Event
- ☐ Alcohol or Drug Problems
- ☐ Arrest or Pending Charges
- ☐ Death of a Close Friend
- ☐ Incarceration or Conviction
- ☐ Major Accident or Injury
- ☐ Significant Weight Loss or Gain
- ☐ Excessive Tiredness
- ☐ Difficulty Sleeping
- ☐ Loss of Appetite
- ☐ Feeling Tense and Uptight
- ☐ Feelings of Loneliness
- ☐ Relocation
- ☐ New Family Member
- ☐ Depressed
- ☐ Nightmares
- ☐ Unusual Thoughts
- ☐ Increase in Number of Arguments
- ☐ Panic or Anxiety Attacks
- ☐ Tremors or Tics
- ☐ Trouble Concentrating
- ☐ Nervous Around Strangers
- ☐ Fear Things I Shouldn't
- ☐ Strange Experiences
- ☐ Drug Problems
- ☐ Excessive Drinking
- ☐ Empty Nest
- ☐ Marital Difficulties
- ☐ Conflict with Family
- ☐ Loss of Interest
- ☐ Involvement in a Law Suit
- ☐ Loss of Job
- ☐ Constant Worrying
- ☐ Sexual Problems
- ☐ Financial Difficulties
- ☐ Feel like Crying
- ☐ Feelings of Worthlessness
- ☐ Difficulty Making Decisions
- ☐ Thoughts of Suicide
- ☐ Suicide Attempt(s)
- ☐ Addiction
- ☐ Court Mandated Treatment

Give a brief description/explanation of above marked boxes: _____

_____

_____

_____

What do you enjoy doing in your leisure time? _____

_____

_____