

Licensed Marriage and Family Therapist
2775 Tapo St. Suite 204 Simi Valley CA 93063
Phone (805) 907-2316

Date: _____

Referred by: _____

Name _____ Age _____ Date of Birth _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Is it okay to call you on your home phone (circle) Yes/No Cell Phone (circle) Yes/No

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

Family Background

Present Marital Status: Married Divorced Separated Widowed
 Cohabiting Single 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: _____

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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 History of: Alcoholism _____ Drug Addiction _____ Mental Illness _____ Prolonged Illness _____

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? (Circle) Yes/No Describe: _____

Previous Therapy Individual Couple Family Group Inpatient
 Outpatient Psychiatrist

Current Concerns:

Goals of Treatment:

Check boxes that are currently relevant:

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

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

What do you enjoy doing in your leisure time? _____
