Date: _____

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:**_____

Cell phone: _____ Alternative **phone #**_____

E-mail: _____

Please indicate where I may leave confidential message(Check all that apply)

Phone: _____ Text: ____ E-mail: _____

Date of Birth: _____ Age**: _____**

Gender: Female: _____ Male: _____ Transgender: _____

Gender Nonconforming: _____ Other: _____

Sexual Orientation: Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___

Queer: ___ Questioning: ___ other: _____Prefer not to answer: ___

Relationship status:

Single___ Married_____ Divorced_____ Ina relationship_____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone number: _____ Email: _____

Referral Information:

Were you referred? Yes: _____ No: _____

If Yes, by whom? _____

What type of service(s) are you currently seeking?

Individual therapy_____ Marital/Couples therapy_____ Family therapy _____

Child therapy___ Other (describe) _____ Unsure___

Goals of Treatment:

What bought you to seek therapy at this time?

_____

Describe your current concerns, issues, or problems that you hope to resolve:

_____

_____

What do you hope to gain from therapy?

_____

_____

Payment Information:
Please indicate how you intend to pay for treatment:

Cash: ___ Venmo: ___ Check: ____Credit Card: ____

Credit Card _____

Exp.Date _____ CCV# _____

Source of Income:

Employed: _____ Unemployed/Social Welfare: _____

Spouse/Significant Other/Parent: _____ Other _____

Current Employment Status (Please check all that apply):

Working Full-Time: _____ Working Part-Time: _____ Retired: ____ On medical leave: _____

Unemployed and looking for work: _____ Not employed due to other reasons ____

Full-TimeStudent: _____ Part-Time Student: _____

Education Information: (Please write the highest level of education/degree you have received):

High School_____ College _____ Post-graduate _____ Other _____

Military History:

Never served in the military: _____

Currently on active duty: _____ Served in Military for: _____ years

If you have served in the military, were you ever deployed? Yes: _____ No: ____

If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

_____

Legal History:

Have you been ordered by the court to participate in this therapy?
Yes: ____ No: ____

If yes, you may be required to supply supporting documentation such as a copy of court order.

Are you currently involved in any kind of litigation or legal dispute?
Yes: _____ No: _____

If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

Previous Mental Health Treatment History

_____

Have you participated in therapy in the past? Yes: _____ No: ____
If YES, please complete the information below:

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other):_____

Phone Number: _____Email: _____

Street Address: _____

City: _____ State: _____

Dates of treatment _____

Focus of treatment: _____

Are you currently seeing another therapist? Yes: No:
If yes, please complete the information below:

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other): _____

Phone Number: _____ Email: _____

Street Address: _____

City: _____ State: _____

Dates of treatment _____

Focus of treatment: _____

Have you ever been **hospitalized because of a mental health disorder**? Yes: _____ No: _____

If yes, please complete the following information:

Reason for hospitalization: _____

Was hospitalization voluntary or involuntary?Voluntary: _____ Involuntary: _____

How long was your hospitalization?

_____

Where were you hospitalized?

_____

Course of treatment during hospitalization:
_____

Information about your hospital stay

Please indicate the type of provider (i.e., Psychiatrist, Psychologist, MD, Licensed Therapist).

Name: _____

Type of Provider (Psychiatrist, Psychologist, Therapist, or Other): _____

Phone Number: _____ Email: _____

Street Address: _____

City: _____State: _____

Dates of treatment _____

Current Mental Health Treatment:

Are you currently under the **care of a psychiatrist**? Yes: ____ No: _____
If YES, please complete the following information:

Name of Current Provider: _____

Phone Number: _____ Email: _____

Street Address: _____

City: _____ State: _____

Dates of Treatment: _____

Focus of Treatment: _____

If you are currently under the **care of a psychiatrist**, are you taking any prescribed psychiatric medication(s)? Yes _____ No_____

If you indicated that you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects. For example: "Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)." Please continue on additional sheet if needed
_____

_____

Have you participated in any psychological assessments or tests? Yes ____ No _____

***California Civil Code Section, 56.10 states that information may be disclosed to "providers of health care or other health care professionals or facilities for purposes of diagnosis or treatment of the patient" without the patient's consent. By initialing, you acknowledge and understand that I may contact either your current or former mental health care and/or medical providers only to discuss issues relevant to your diagnosis and treatment without your consent.** Initial: _____

Medical Treatment Information:

Are you currently seeking treatment for a serious or chronic non-psychiatric medical condition?
Yes: _____ No: _____.

If you currently have a medical condition, please provide the following information:
Current medical condition: _____

How long have you had the condition? _____

Is it a medically treatable condition? Yes: _____ No:
If, it is not a medically treatable condition (i.e., palliative care), please describe:

_____

If you are currently taking prescribed medications, please describe the type of medication, indicate how long you have been taking the medication, and any side effects. For example: "High blood pressure medication (type of medication); 2 years (length of time on medication); Drowsiness (example of a side effect). Please continue on additional sheet if needed.

_____

_____

Primary Care Physician:
Name: _____

Phone Number: _____ Email: _____

Street Address: _____

City: _____ State: _____

Dates of Treatment: _____

Are you experiencing any suicidal/ homicidal ideation or attempts?
Yes No
If yes please provide more details: _____

Current or past Drug/Alcohol/Eating disorders?
Yes No
If yes please provide more details: _____

Trauma History (Optional):

Have you been, or are you currently being, emotionally, physically, or sexually abused?
Yes _____ No _____ Prefer not to answer _____

If you checked "Yes," you may use the space below to describe the underlying circumstances:
_____

_____

Client Signature _____ Date _____

Client Name: _____
(Please Print)