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(MFC # 49952)
Licensed Marriage and Family Therapist, M.S.
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Client Contact Information and Health Questionnaire:

Name: _____Date of Birth_____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Which number would you prefer me to use when contacting you? _____
May I leave a message at this number? Yes or No

*Email: _____ *(Note: Your WORK email is not private and secure. Your employer has access to your private health information if you use a work email address.)

Relationship Status (circle one): S (single), D (divorced), M (married), W (Widowed)
SE (Separated) C (Committed relationship) O (Other)

Occupation_____Degree/Training_____

Names and ages of any children

_____

Emergency Contact Person: _____Phone # 1_____
Relationship to You: _____ Phone# 2_____

NOTE: Please know your responses to the following questions will be kept confidential unless you provide written permission to release this information should your treatment require this action. Thank you for your honesty.

What issues/concerns have brought you here today? Please briefly describe. _____

_____

_____

Do you have any specific goals that you would like to address?

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

Mental Health History

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

_____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

What was your mental health condition at the time?

_____

Name of treating therapist/s, city and state:

_____

_____

Are you currently taking any prescription medications? _____

List **Prescription Medications**, prescribing **physician**, and **date** (month/year):

_____

_____

_____

Have you ever taken any medications for a mental or emotional condition? _____

When and for how long?

_____

Have you ever attempted suicide? _____ When?_____

Briefly describe the circumstances that led to that attempt.

_____

Are you currently having any suicidal thoughts? Please describe

_____

_____

Please describe your childhood in a few words

_____

Have you ever been subjected to verbal, physical, emotional, or sexual abuse? When?

_____

_____

_____

Have you ever been a victim of a violent crime? Please describe _____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe_____
_____

Do you have any medical conditions that may affect your mental health treatment?
_____

Please describe your overall health today.
_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____
_____

Have you ever been in a 12-step program?
_____

Do you smoke? _____ How much? _____ For how long? _____
Do you drink alcohol? _____
On average, how much alcohol do you consume in a week?_____
Do you currently use illegal drugs? Please describe your use _____
_____

Have you ever used illegal drugs? Please describe. _____
_____

Other Information: Please list any family history or events that you feel may be relevant to your therapy:
_____
_____
_____

Please describe any spiritual identity/orientation.
_____
_____

Please feel free to include any other information that you believe is relevant to your mental health treatment that was not previously requested.
_____
_____
_____

I attest that I have answered the previous questions in a true and honest manner.

Signature_____Date_____

Thank you for trusting me to help you take the next step in your life.