Sheryl A. Isaacs, MS, LMFT
Licensed Marriage and Family Therapist #92557
5523 Scotts Valley Drive, Scotts Valley, CA 95066
831-431-7996
www.therapyforyourchild.com

General Information

Name: _____

Address:_____

**** Please check boxes where discreet messages may be left.***

□Home phone _____□Work phone _____□Cell _____

□E-mail _____ Referred by _____

Age _____ Date of birth _____

Marital status _____ Educational level _____

Occupation _____ Names and ages of children_____

_____

Emergency contact information _____

Spouse/Partner Information

Name: _____

Address:_____

Age _____ Date of birth _____

Educational level _____ Occupation _____

Names and ages of their children_____

Spouse's medical issues _____

Spouse's current medications _____

Financial Information

How do you intend to pay for treatment? (cash, check, charge, insurance) _____

If planning to use health insurance:

Name of insurance company _____

Policy number _____ Group number _____

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Telephone number _____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

_____

_____

_____

Do you have any specific goals with regard to your treatment? _____

_____

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

_____

_____

Psychological History

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s), address(es), telephone number(s) _____

_____

***Authorization for release of confidential information will be needed so that any former therapist may be contacted**.

Have you ever been subjected to one or more psychological tests? _____

If so, by whom? _____

Name of person(s) administered psychological tests, address(es), telephone number(s)

_____

_____

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

When and for how long? _____

Why were you hospitalized? _____

Name of treating therapist, address, telephone number _____

Are you currently taking any prescription medications? _____

Prescribed by whom? _____

How long have you been on the medications? _____

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

When and for how long? _____

***Authorization for release of confidential information will be needed so that health care provider may be contacted.**

Have you ever attempted suicide? _____

When? _____

Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? Please describe _____

_____

_____

Please describe your childhood. _____

_____

_____

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Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

_____

_____

_____

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? Please describe. _____

_____

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 _____

_____

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Have you ever used illegal drugs? Please describe. _____

_____

Primary Care Physician _____ Phone_____

Psychiatrist (if applicable)_____ Phone_____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother.

_____

_____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father.

_____

_____

_____

Names and ages of siblings. _____

_____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____

_____

Probation Officer _____ Phone_____

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Social Worker _____ Phone_____

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

_____

_____

_____

Consent to be contacted for follow up: Do you give permission for a discreet letter to be sent to your home address to check in and see how you are doing after therapy? □Yes □No