Suzann McIntire, M.S.
Licensed Marriage and Family Therapist #52701
626-214-5271

Today's Date: _____

Name: _____ Age: _____ DOB: _____

Address: _____ City & Zip Code: _____

Primary Phone #: _____ Home/Cell/Work – May I leave Message? ☐Yes ☐No

Alternate Phone #: _____ Home/Cell/Work – May I leave Message? ☐Yes ☐No

Email: _____ Business #: _____

Occupation: _____

Emergency Contact: _____ Relationship to Client: _____

Emergency Contact #: _____

Currently enrolled/attending school?: ☐Yes ☐No

Are you currently serving/have a history of serving in the military? ☐Yes ☐No

How were you referred? _____

*****Email & Text Message correspondence are not considered a confidential medium of communication*****

Primary Language: _____ Secondary Language: _____

Ethnicity: _____ Religious/Spiritual Affiliation: _____

Marital Status: ☐ Married ☐ Cohabitating ☐ Domestic Partnership ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

Current Living Situation: _____

Children: ☐Yes ☐ No If yes, children's ages: _____

**Complete if client is under the age of 18**

Parent/Legal Guardian #1 Name: _____ Age: _____ DOB: _____

Primary Phone Number: _____ ☐ Home ☐ Work ☐ Cell

Address: _____ City & Zip Code: _____

Parent/Legal Guardian #1 Name: _____ Age: _____ DOB: _____

Primary Phone Number: _____ ☐ Home ☐ Work ☐ Cell

Address: _____ City & Zip Code: _____

Legal Custody of Minor Held by: _____

Physical Custody of Minor Held by:

**Medical Information**

Have you had a physical with a physician in the last year? Yes ☐ No ☐

Do you exercise? Yes ☐ No ☐

If yes, please describe your exercise routine/activities: _____

Do you have a history of or currently experience any medical/health issues? Yes ☐ No ☐

If yes, please describe:

Current medications/vitamins/herbal supplements: _____

Are you experiencing any of the below symptoms:

☐ Sleep Disturbances ☐ Loss/increase in appetite ☐ Sudden loss/increase in energy

☐ Headaches ☐ Vision Problems ☐ Dizziness/Fainting ☐ Hearing Problems

How often do you consume alcoholic beverages?

☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily ☐ Never

How often do you engage in recreational drug use?

☐ Infrequently ☐ Monthly ☐ Weekly ☐ Daily ☐ Never

**Mental Health Information**

Have you ever received/currently receiving any type of mental health services? Yes ☐ No ☐

If "yes", name of therapist, approximate dates and focus of treatment:

_____

Have you ever received psychiatric services? Yes ☐ No ☐

If "yes", name of psychiatrist approximate dates and focus of treatment:

Are you currently taking psychotropic medications? Yes ☐ No ☐

If yes, please list medications: _____

Do you have a history of taking prescribed psychotropic medications? Yes ☐ No ☐

If yes, please list medications: _____

Have you <u>ever</u> experienced the following symptoms?

☐ Anxiety ☐ Depression ☐ Phobias ☐ Panic Attacks ☐ Flashbacks ☐ Chronic Pain

☐ Grief ☐ Suicidal thoughts/feelings ☐ Thoughts/feelings of wanting to harm self

Have you ever experienced or encountered any of the following?

| | | |
|---|---|---|
| ☐ Emotional Abuse | ☐ Physical Abuse | ☐Sexual Abuse |
| ☐ Neglect | ☐ Living in Foster Care | ☐ Violence in the home |
| ☐ Multiple homes/living situations | ☐ Victim of Crime | ☐ Homelessness |
| ☐ Substance use by parent | ☐ Substance use by partner | ☐ Loss of loved one |
| ☐ Financial hardship | ☐ Major Surgery/Medical Procedure | ☐ Major accident/serious illness |

Do you have a family history of the following (if yes, indicate the family member's relationship to you in the space provided to the right)?

| | | |
|---|---|---|
| Alcohol/Substance Use | Y ☐ N ☐ | _____ |
| Anxiety | Y ☐ N ☐ | _____ |
| Bi-Polar Disorder | Y ☐ N ☐ | _____ |
| Depression | Y ☐ N ☐ | _____ |
| Domestic Violence | Y ☐ N ☐ | _____ |
| Eating Disorders | Y ☐ N ☐ | _____ |
| Obesity | Y ☐ N ☐ | _____ |
| Obsessive Compulsive Behaviors | Y ☐ N ☐ | _____ |
| Post-Traumatic Stress Disorder | Y ☐ N ☐ | _____ |
| Schizophrenia | Y ☐ N ☐ | _____ |
| Suicidal Ideation/Behaviors | Y ☐ N ☐ | _____ |

**Therapeutic Focus**

Please identify any of the below concerns that you would like to work on and/or areas you would like to receive support with during therapy:

| | | | |
|---|---|---|---|
| ☐ Accident or injury | ☐ Addiction | ☐ Alcohol or Drugs | ☐ Anger |
| ☐ Bereavement | ☐ Career Goals | ☐ Child/Parenting | ☐ Communication |
| ☐ Conflict Resolution | ☐ Depression | ☐ Disturbing/troubling thoughts | |
| ☐ Divorce/Separation | ☐ Familial Conflict | ☐ Gender identity | ☐ Grief |
| ☐ Hopelessness | ☐ Infertility | ☐ In-laws | ☐ Intimacy Barriers |
| ☐ Job related issues | ☐ Loss | ☐ Marriage | ☐ Motivation |
| ☐ Pregnancy | ☐ Relationship | ☐ School | ☐ Self-Esteem |
| ☐ Sexuality | ☐ Spirituality | ☐ Stress | ☐ Suicidal Thoughts |
| ☐ Trauma | ☐ Anxiety | ☐ Postpartum related issues | |

Any additional information related to why you are seeking therapy at this time or what may be helpful for your therapist to know: