Alyssa Rand, MA, MFT
Licensed Marriage and Family Therapist
License # 90050

Confidential Client Information

General:

Name ___________________________________

Date ____________________________

Phone __________________________

Address

____

____

E-mail __________________________________

Referred by ______________________

Age ____________________________________

Date of birth ____________________

Instagram Handle ________________________

Marital/Relationship status_________________

Educational level ________________

Spouse/Partner's Name and Age_____________

____

Occupation ____________________________

Work phone ____________________

Work Address___________________________

____

Names/Ages of Children____

Emergency contact information ____

How may client be contacted by therapist _______phone _______text _______email

Family Doctor/Psychiatrist___________________ phone__________________________

Areas of Concern

What issues/concerns cause 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? ____

Was it helpful? Why or Why

Not?____

____

Name of treating therapist(s), telephone number(s): ____________________

____

____

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

____

When and for how long? ____

Name of treating therapist, telephone number: ____________________________

Are you currently taking any prescription medications/doses?

____

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? ____

Were you ever subjected to verbal, physical, emotional, or 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:____
____
____
____

Have you ever had a history of, or experienced headaches/head trauma/concussion or loss of consciousness?____
____

If so, did you see a Physician?
Name/Date____

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

Please describe your overall health today and any physical problems:
____
____
____

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? ____________ Frequency? _______________
Do you drink alcohol? _____________
On average, how much alcohol do you consume in a week (ounces)?_____________
Do you currently use illegal drugs? Please describe your use:_______________________

Have you ever used illegal drugs? Please describe. ______________________________

Family of Origin History

Mother's name, age, occupation, living/deceased, client's age at the time of mother's death, description of relationship with mother:______________________________

Father's name, age, occupation, living/deceased, client's age at the time of father's death, description of relationship with father:

Were you raised by: Both Parents_____Single Parent_____Rel._____ Other_____

Names and ages of siblings (including self) in birth order:

Family History Of: Alcoholism_____ Drug Addiction_____ Suicide_____

Mental Illness_____ Chronic Illness_____

Please briefly describe your childhood:_________________________________

____
____
____
____
____
____
____
____
____

Words you associate with the home you grew up in:____

____
____

How would you describe yourself as a child, including hobbies and interests and joys:____

____
____
____
____
____
____

Other Information

Please describe your spiritual identity/orientation:

____
____

Please describe your interests/hobbies:

____
____
____
____

Do you follow a specific diet or have any particularly strong food cravings?____
____
____

What are three qualities of people you admire:____
____

What are three qualities of people you judge or detest:____
____

Do you have dreams which standout to you or repeat? Briefly Explain:____
____
____
____
____

If you could meet anyone, real or imagined, alive or deceased whom would it be and why?____
____
____
____

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

Please describe the
lawsuit:____
____
____
____
____

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

Client's Signature________________________________ Date:____/____/____

Legal Guardian Signature:________________________ Date:____/____/____