PAULETTE CLARK

Licensed Marriage Family Therapist, CA MFC 43338
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PERSONAL INFORMATION

Today's Date_____ Referred By _____

Please provide the following information:

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in my consent to treatment.

Name _____ Male _____ Female ___

Address _____ City _____ Zip Code _____

Phone numbers: Home ( )___-_____Cell ( ) ___-_____ Work ( )___-_____(Please star the best number to reach you.) May we call you at home? Y/N; at Work? Y/N

Age _____ Birthday _____ E-mail address _____

Occupation _____ Employer _____

Work Address _____ City _____ Zip Code _____

Previous Occupation _____ Highest Grade Completed _____

Would you like spirituality/religious issues to be a part of your therapy? Y / N / Don't Know
Note: It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.

In your own words, please state the nature of the main reason you are seeking therapy?

How would you rate how serious this issue feels to you? (Circle one) 1 2 3 4 5
Mildly upsetting Extremely Serious

What would you like to accomplish through therapy?

Family Information:

Present marital status: Single____ Married ____ Divorced ___ Separated ___ Widower ____ Significant Other___

If married: Name of Spouse _____ Age of Spouse _____ Date of Marriage _____

Marital satisfaction:

Would you describe your intimate relations as satisfactory or unsatisfactory? _____

If separated: Date of Separation: ___ If divorced: Date of marriage to ex-spouse _____ Date of Divorce ___

If divorced more than once: Date of previous marriage _____Date of previous divorce _____

If you have a "Significant Other": Name _____How long known ____ Living together? _____

Children: Names and Ages of Children _____

_____

_____

Other children living with you: Names, ages, and their relationship to you _____

_____

FAMILY HISTORY

Did you grow up with both parents in the home? Y/N Step-father: Age_____ Stepmother: Age____.

Adopted?

On a scale of 0-10, 10 being the most, please rate the level of stress in your home while you were growing up:_____

In your own words, please describe, from your experience, what the tension was about or who was creating the tension:

Who did you feel the closest to? Your Father___Mother___Neither___Other (please specify) _____

Father: Age ___ Occupation _____Living? Y/N; Physical and emotional health:

Briefly describe your relationship with your Father:

Mother: Age ___ Occupation _____ Living? Y/N, Physical and emotional health:

Briefly describe your relationship with your Mother:

Siblings: (please give first name, age, and brief description including if they were anxious, depressed, had drug or alcohol problems, learning disabilities, etc.)

Name Age Description and your relationship with them:

_____

_____

Name Age Description and your relationship with them:

_____

_____

_____

_____

Has any member of your family ever suffered from anything that could be described as an "emotional" or "psychological" problem? _____

_____

Please mention any history of domestic violence, child abuse or sexual abuse in your family: _____

_____

Please comment on any history of alcohol or drug use in your family: _____

_____

Describe yourself as a child. What messages did you receive from your parents (or other significant caregivers) about yourself (e.g., "you're special," "you're a burden," "you're not important/loveable," etc.). How did you respond to these messages? Do you think they still impact you today? If so, in what way? If not, why not?

EMOTIONAL HISTORY:

Please indicate which symptoms you have experienced and rate the severity **(** 1-Never, 2 - Seldom, 3-Sometimes,4-Often. Please include any other information that is relevant.)

	Anger management problems		Getting stuck on thoughts or worries
	Depression		Compulsivity
	Anxiety		Self Harm
	Brain fog or confusion		Thoughts of suicide
	Hopelessness		Problems learning, difficulty paying attention
	Mood Swings		Other
	Irritability		

Have you ever had any previous counseling or psychotherapy? When? How long were you in therapy? Was therapy successful?

Have you ever been hospitalized for psychiatric reasons? Y/N If yes, when?_____Length of hospital stay _

Other prior treatment:

ALCOHOL AND DRUG HISTORY:

Please indicate any of the following that you have used or are using and give a brief description of how often and how much you have used this. Please include information about current use.

Alcohol

Tobacco

Marijuana

Cocaine

Heroin or derivatives (Percocet, Vicodin, Oxycontin, etc.)

Amphetamines

Hallucinogens (LSD, mushrooms, Ecstasy, etc.)

Other:

What was the hardest time in your development ___Preschool ___Grade School ___Jr. High __High School College ___Now

TREATMENT AND MEDICAL HISTORY

Please place a number beside each illness or condition to indicate the frequency or severity: 1-Never, 2 - Seldom, 3-Sometimes,4-Often. Please feel free to include any further information you feel is relevant.

	Learning disability, please describe:		Heart problems, High blood pressure, etc
	Over-eating/ under-eating; weight management problems		Thyroid problems

	Body pain		Clinical Depression
	Asthma or allergies		Panic attacks
	Insomnia or other sleep problems		Mood Swings
	Headaches: migraine or tension		Diagnosis of any "terminal illness"
	Stomach problems: indigestion, nausea, constipation, diarrhea		Physical limitation:
Head injury including fevers over 105. Also please provide information about any birth trauma.			
Other: (major illnesses, accidents, birth defects, etc.)			

Current Weight _____One Year Ago _____Maximum_____When?_____

Do you exercise regularly and what do you do for exercise?

Do you have problems falling asleep? Staying asleep? How much sleep a night do you get on average? Please describe:

Date of last physical exam: Physical diagnoses or problems:

Please list all medications and how often you use it. Please comment on its effectiveness and side effects.

Do you consider your diet to be healthy or unhealthy? Caffeine use? Special diets?

Do you take vitamins? Please List:

GENERAL CONSENT TO THERAPY

I apply for and consent to counseling, psychotherapy and diagnostic testing as prescribed by the therapist. I agree to be responsible for the payment of $145 per session (45/50 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company. I also understand the "no cancel" policy and that any missed appointments will be charged at the agreed upon rate. The appointment may be rescheduled for no charge at another time. Only one "missed appointment" is eligible to be rescheduled at a given time. In the case there are two missed appointments, the earliest appointment will be cancelled.

Signature _____

OTHER INFORMATION YOU WOULD LIKE FOR ME TO KNOW: _____

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Thank you!