Ross Bryan MA LMFT
Psychotherapy

Licensed Marriage and Family Therapist / State of California MFC 51858
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PATIENT INTAKE QUESTIONNAIRE

General

Name:

Date:

Address	City/St	Zip
Phone: HM May we leave a message?	WK May we leave a message?	MOBILE

Email address (Please note that email correspondence is not considered to be a confidential form of communication):

Date of Birth:	Age:	Occupation:
Education Level:	Do you enjoy your work? Is there anything stressful about your current work, please describe:	
Marital Status:	Name of Emergency Contact: Contact Number:	

Referred by:

Number of Children:	Name/Age:
Name/Age:	Name/Age:
Name/Age:	Name/Age:

Financial Information

Annual Household Income (optional): Do you own or rent? (optional)

How do you intend to pay for treatment: Cash Check CC Insurance (circle which apply)

Insurance – Name of Ins. Co. Telephone Number:

Policy Number: Group or ID Number:

Areas of Concern

What issues/concerns causes you to seek counseling? Please describe:

List any specific goals you may have with regard to counseling?

Describe, if any, particular concerns or fears with regard to counseling?

Health Information

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

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

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

List any specific sleep problems you are currently experiencing: _____

How many times per week do you generally exercise? _____ What types of exercise do you participate in?

Do you drink alcohol? _____ On average, how much alcohol do you consume in a week? _____

Do you smoke tobacco? ____ How much? _____ How long? _____ Do you currently use recreational drugs? _____

Please describe your use: _____

Have you ever used recreational drugs? Please describe: _____

Have you ever been in a 12-step program, describe: _____

List any difficulties you experience with your appetite or eating. _____

Are you currently experiencing overwhelming sadness, grief or depression? _____ If yes, how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? _____ When did this begin? _____

What chronic pain are experiencing? _____

Are you currently taking any prescription medications? _____ How long? _____

List and prescribed by whom? _____

What do you consider some of your strengths? _____

Please describe your sexual orientation: _____

Please describe your spiritual/religious orientation:_____

Psychological History

Have you received mental health treatment before? _____ When/how long? _____

What was the focus of treatment? _____

Name of treating therapist, address, telephone numbers. _____

Have you ever taken any medications for a mental or emotional condition? _____ When and how long? _____

Have you ever been participated in one or more psychological tests? _____

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

Why were you hospitalized? _____

Name of treating therapist, address, telephone numbers: _____

Have you ever attempted suicide? _____When? _____ Describe circumstances that led to the attempt:

_____

Are you currently having any suicidal thoughts? _____ Please describe: _____

_____

Please describe your childhood: _____

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

_____

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

_____

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

Please describe:_____

_____

Family History

Mother's name: _____ Age: _____ Living or deceased? _____

Patient's age at the time of mother's death: _____ Please describe relationship with mother:

_____

Father's name: _____ Age: _____ Living or deceased? _____

Patient's age at the time of father's death: _____ Please describe relationship with father:

_____

Number of Siblings: _____

Name/Age:	Name/Age:
Name/Age:	Name/Age:
Name/Age:	Name/Age:

Please feel free to include any additional information the you believe is relevant to your mental health treatment.

_____