VERA ECK, M.A., LMFT
Psychotherapy
1452 26th Street, Suite #203
Santa Monica, CA 90404

(PLEASE PRINT)

TODAY'S DATE _____

NAME _____ AGE _____ BIRTHDATE _____

___single ___married ___widowed ___divorced ___separated

ADDRESS _____ OCCUPATION _____

CITY _____ STATE _____ ZIP ____ BIRTHPLACE _____

MEDICAL INSURANCE _____

EMPLOYER _____ HOME PHONE _____

WORK ADDRESS _____ CELL PHONE _____

CITY _____ STATE _____ ZIP ____ RELIGION _____
(optional)

EMAIL ADDRESS _____

REFERRED BY _____

PERSON TO NOTIFY IN EMERGENCY _____

PHONE # _____ RELATIONSHIP _____

MEDICINE PRESENTLY TAKING _____

THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE

_____

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED,
UNLESS ARRANGMENTS ARE MADE IN ADVANCE.

_____

PATIENT SIGNATURE _____

SYMPTOM CHECKLIST

___ fear

___ sadness

___ grief

___ frustration

___ anxiety

___ panic

___ irritation

___ intense anger

___ guilt

___ remorse over past events

___ tearfulness

___ crying

___ confusion

___ inability to rest

___ difficulty sleeping

___ inability to sleep

___ too much sleep

___ waking up too early

___ nightmares

___ night terror

___ headaches

___ increased blood pressure

___ increased sexual desire

___ decreased sexual desire

___ feeling overwhelmed

___ heightened/lowered alertness

___ increased alcohol use

___ decreased alcohol use

___ difficulty making decisions

___ poor concentration or memory

___ loss of appetite

___ increased appetite

___ withdrawal from family

___ headaches

___ chest pain

___ recurrent thoughts of death

___ wanting to die

___ planning to die

___ persistent intrusive images

___ inability to feel anything/numb

Note: Please add any additional symptoms not listed here, that you are noticing on the back of this form. Thank you.

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) _____

_____

(Written Authorization for Release of Confidential Information would be needed to contact any former therapist.)

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)

_____

_____

__

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? _____

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 _____.

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 _____

_____

Have you ever used illegal drugs? Please describe. _____

_____

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. _____

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