

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

- | | |
|---|--|
| <input type="checkbox"/> fear | <input type="checkbox"/> headaches |
| <input type="checkbox"/> sadness | <input type="checkbox"/> increased blood pressure |
| <input type="checkbox"/> grief | <input type="checkbox"/> increased sexual desire |
| <input type="checkbox"/> frustration | <input type="checkbox"/> decreased sexual desire |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> feeling overwhelmed |
| <input type="checkbox"/> panic | <input type="checkbox"/> heightened/lowered alertness |
| <input type="checkbox"/> irritation | <input type="checkbox"/> increased alcohol use |
| <input type="checkbox"/> intense anger | <input type="checkbox"/> decreased alcohol use |
| <input type="checkbox"/> guilt | <input type="checkbox"/> difficulty making decisions |
| <input type="checkbox"/> remorse over past events | <input type="checkbox"/> poor concentration or memory |
| <input type="checkbox"/> tearfulness | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> crying | <input type="checkbox"/> increased appetite |
| <input type="checkbox"/> confusion | <input type="checkbox"/> withdrawal from family |
| <input type="checkbox"/> inability to rest | <input type="checkbox"/> headaches |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> inability to sleep | <input type="checkbox"/> recurrent thoughts of death |
| <input type="checkbox"/> too much sleep | <input type="checkbox"/> wanting to die |
| <input type="checkbox"/> waking up too early | <input type="checkbox"/> planning to die |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> persistent intrusive images |
| <input type="checkbox"/> night terror | <input type="checkbox"/> 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. _____