CONFIDENTIAL Golshid Fadakar, Licensed Marriage and Family Therapist, Lic. # 98546
Licensed Professional Clinical Counselor, Lic. #4459
2522 Chambers Rd, Suite 100, Tustin, CA 92780 Telephone (949) 415-4996

Today's Date: ____________________________

Name: ____ Birth Date: ___________________

Home Address: ____ City: _________________________ Zip: __________

Home Phone: _______________________ Cell Phone: __________________________ E-mail: _____________________

Circle the number you prefer me to call you at: Home Cell . Can I leave you a message? At Home ? Y / N - Your Cell? Y / N

You may contact me by e-mail and by text regarding your appointments. Please initial here __________ if you give me the permission to return your e-mails and texts.*

* Please note: E-mail and text correspondence are not considered to be confidential media of communication.

Emergency Contact Name: ____ Phone: _________________________

Gender: M/F Age: ______Your Occupation: _____________________________ Education: ____________________

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Years Married (Together): ______ Spouse's (Partner's) Name: ________________________________ His / Her Age: _____

His / Her Education: __________________________________ His /Her Occupation: _______________________________

Children, their names and & Ages: ____

Who referred you? ____

Who do you presently live with? ____

Is this working for you? ____

What brought you here today? ____

What are your goals for counseling? ____

Do you have any fears or concerns about being in counseling? ____

Have you experienced a traumatic event in recent years? If yes please describe. _______________________________________

____

Are you experiencing stress in any of these areas?

Grief: ____ Financial: ____

Work: ____ School: ____

Relationships: ____________________________________ Family: ____

Legal: ____ Other: ____

Who are the people you feel emotionally supported by?

Family: ____ Friends: ____

Spiritually: _______________________________________ School: ____

Work: ____ Professionals: ____________________________________

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What is your use of substances? (approximately)

Substance **Amount** **Frequency** **Last Use**

Alcohol: ______________________________

Prescription: ______________________________

Recreational Drugs: ______________________________

Other: ______________________________

Do you have a history of Seizures _____ Hallucinations _____ Blackouts _____ Scary Thoughts _____
Confusion _____ Tremors _____ Other ______________________________

Previous Counseling Experience – Outpatient / Inpatient

When With Whom: Where: Frequency: Diagnosis

____

____

____

Are you currently working with any other doctor, therapist, psychologist, group, etc.? Y / N

If Yes, explain: ______________________________

May I contact them? Y / N Name: ____________________ Phone: ____________________

Y / N Name: ____________________ Phone: ____________________

Have you taken any psychiatric medications in the past at any time?

Antidepressants: ______________ Antianxiety: ______________ Antipsychotics: ______________

Medical History

Current Medical Problems: ______________________________

Name of Physician: ______________________________

Could I contact them to coordinate your care, if necessary? Y / N Phone #: ______________________________

Are you currently taking any medications? For What Dosage

____

____

Have you experienced any of the following in the past year?

[ ] Fatigue / Sleep Disturbance: ______________________________

[ ] Depression / Extreme Sadness: ______________________________

[ ] Loss of Interest in Daily Activity: ______________________________

[ ] Panic / Anxiety: ______________________________

[ ] Decreased Concentration / Memory Loss: ______________________________

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Have you experienced any of the following in the past year? *(continued)*

[ ] Mood Swings: ______________________________

[ ] Weight Gain / Loss: ______________________________

[ ] Excessive Worthlessness / Guilt: ______________________________

[ ] Paranoia / Obsessive Behavior: ______________________________

[ ] Isolation / Loneliness: ______________________________

Have you ever attempted or seriously considered suicide? ______________________________

When? ______________________________

Have you ever engaged in self-mutilation/cutting/burning? Y / N Specify how? ______________________________

Have you any concerns about your sexuality with your partner or for your partner or for yourself? Y / N

Any: [ ] Heart Palpitation [ ] Difficulty Breathing [ ] Stomach Problem [ ] Diabetes [ ] Other ______________

Any disabilities including visual / auditory? Y / N Describe: ______________________________

Your family of origin information:

	Father	Mother	Brother or Sister	Brother or Sister	Brother or Sister	Brother or Sister	Brother or Sister
Name							
Age							
Education							
Occupation							
History of Mental Illness if any							

Thank you very much for taking the time and care to complete this form.