Golshid Fadakar, LMFT, LPCC
Licensed Marriage and Family Therapist Lic. #98546
Licensed Professional Clinical Counselor Lic #4459
(949) 229-1043 • goldie@goldiefadakar.com

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 form of communication.

Emergency Contact Name: _____ Phone: _____

Gender Identity: Male Female Non-Binary Transgender_____ Intersex Other_____

Sexual Orientation: Heterosexual/Straight Gay/Lesbian Bisexual Questioning Other_____

Age: _____Your Occupation: _____ Education: _____

How do you identify, culturally (ethnicity, race, religion, etc.)? _____

Marital Status: Never Married Domestic Partnership Married Separated Divorced Widowed

Years Married (Together): _____ Spouse's (Partner's) Name: _____

His / Her /Their Age: _____

His / Her /Their Education: _____ His /Her/Their Occupation: _____

Please list any dependents (Children/Parents and Ages):

_____

How did you hear about me?

_____

Who do you currently live with? Is this working for you?

_____

_____

What brought you here today? Be specific as you can: when did it start, how does it affect you.

_____

_____

Severity of above problem: Mild Moderate Severe Very severe

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What are your goals for counseling?

_____

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

_____

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: _____

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 _____ Delusions _____ DUI/DWI _____
Nightmares_____ Surgeries_____ Other_____

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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: _____ Other: _____

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/ Shane: _____

[ ] Paranoia / Obsessive Thoughts/Behavior: _____

[ ] Isolation / Loneliness: _____

[ ] Suicidal Ideations:_____

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

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

Other _____ Any disabilities including visual / auditory? Y / N

Describe: _____

Personal and Family Mental Health History:
In the section below, identify if there is a family history-including yourself- of any of the following. If Yes, please indicate the family member's relationship to you in the space provided (self, parent, grandparent, aunt/uncle, brother/sister, etc.)

	Please Circle	List Self or Family Members (s)
Alcohol/Substance Abuse	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obsessive Compulsive Behavior	Yes/No	
Schizophrenia	Yes/No	
Suicide Attempts	Yes/No	
Violent/Assault Behavior	Yes/No	
Other (Describe)		

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Briefly describe or list significant events from childhood and/or adulthood (e.g. relationship with family, behavioral issues, divorce, trauma, etc.):

_____

_____

Additional Information:
Do you currently have employment/source of income? □ No □ Yes
Please describe:

_____

_
Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

What do you consider to be some of your strengths?

_____

_____

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