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: __________

Cell Phone: _____________________ Home Phone: _____________________ E-mail: ______________________

Circle the number you prefer me to call you at: Home Cell

Can I leave you a general voicemail? At Home ? Y / N - 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

Are you currently in a romantic relationship? Y / N

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

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, psychiatrist, psychologist, group, etc.? Y / N

If Yes, explain:____

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

Antidepressants: _______________________ Antianxiety: ___________________________

Antipsychotics: ________________________ Other: _______________________________

Medical History

Current Medical Problems (please be specific):

____

Name of Physician:

____

Are you currently taking any medications, supplements, vitamins? For What Dosage

____

____

How many times per week do you generally exercise? ____

Type of exercises: ____

Please describe any difficulties with your appetite or eating patterns: ________________________________

____

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.):

____

____

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce or custody disputes? If yes, please explain:

____

____

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?

____

____

Please feel free to include any other information you feel would be helpful to your treatment:

____

____

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