Serena Gupta, LMFT

Licensed Marriage and Family Therapist

Confidential Information

Date: _____

Name: _____ Birth date: _____

Home Address: _____ Age: _____

City, State: _____ Zipcode: _____

Employer: _____ Occupation: _____

Address: _____

Phone: Home: _____ OK to leave message - yes no

Work: _____ OK to leave message - yes no

Cell: _____ OK to leave message - yes no

Email Address: _____ OK to leave message - yes no

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced

Partner Name: _____ Age: _____

Children / Others Living With You:	Age:	School / Occupation:	Grade:
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____
Name: _____	_____	_____	_____

Medical Information:

Primary Care Physician: _____

Last medical exam: _____

Have you ever been diagnosed with a serious illness? Please describe: _____

_____

_____

Medications that you are currently taking: _____

_____

Do you have any medical conditions that may affect your mental health treatment? _____
Please describe: _____

_____

_____

Please describe your overall health today. _____

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 recreational drugs? If so, please describe your use:

_____

_____

Have you ever used recreational drugs? If so, please describe:

_____

_____

Are you seeing a psychiatrist?

Yes _____ No _____ Last appointment: _____

Psychiatrist Name: _____

Psychiatric Medications: _____

Circle any of the following problems that you experience:

Lack of appetite	Sleep disturbances	Flashbacks
Excessive drinking	Headaches	Difficulty relaxing
Anger management	Sexual problems	Fears/phobias
Problem drug use	Appetite disturbances	Obsessive thoughts
Fatigue	Stomach problems	Compulsive behaviors
Panic Attacks	Low self esteem	Marital/family problems
Anxiety	Relationship problems	Poor impulse control
Loneliness	Difficulty concentrating	Confusion
Nightmares	Depression	Difficulty trusting

Pain (where)_____

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? _____

_____

_____

What do you consider to be your strengths? _____

_____

Do you have individuals/groups/values which support and nurture you? Please explain: _____

_____

Prior History of Counseling: yes no

If yes, when and why did you seek therapy? _____

_____

Therapist: _____

Was it helpful? Please explain: _____

Any additional information you'd like to add? _____

_____

_____

Emergency Contact: _____Relationship_____

Referred by: _____

Thank you.