Jeannette Harroun
Licensed Marriage and Family Therapist
License No. MFC 51366
3468 Mt. Diablo Blvd, B-301, Lafayette, CA 94549
(925) 890-7478

Client Information

Please provide the following information and answer the questions below. Bring the form to your first session. Information you provide here is protected as confidential information.

Name: ______________________ **Date:** ______________

Address: ______________________________________

Birth Date: ______________ **Age:** **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married
☐ Divorced ☐ Widowed

Please list children/age ______________________________

Home Phone: ______________________ May I leave a message? ☐ Yes ☐ No

Cell Phone: ______________________ May I leave a message ☐ Yes ☐ No

Email*: ______________________ May I email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered a confidential form of communication.

Emergency Contact: ______________________________
Name Relationship to you

Emergency Contact Phone Number: ______________________

Referred by (if any): ______________________________

If you need more space for any of the following questions please use the back of the sheet.

Primary reason (s) for seeking services:

____

____

Have you previously received any type of mental health, psychotherapy or psychiatric services?

☐ Yes ☐ No

If yes, please provide the name of the previous practitioner: ______________________

Are you currently taking any prescription medication?

☐ Yes ☐ No

Please list: ______________________

Have you ever been prescribed psychiatric medication?

☐ Yes ☐ No

Please list and provide dates ______________________

General Health information

How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing:

____

How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing:

____

How many times per week do you generally exercise? ______________________

What types of exercise do you do? ______________________

How would you rate your current eating habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific difficulties you experience with your appetite or eating patterns.

____

Are you currently experiencing overwhelming sadness, grief or depression?

☐ Yes ☐ No

If yes, for how long (days/week etc) ______________________

Are you currently experiencing stress, anxiety, panic attacks or any phobias?

☐ Yes ☐ No

If yes, when did you begin experience this? ______________________

Are you currently experiencing chronic pain?

☐ Yes ☐ No

If yes, please describe: ______________________

Do you drink alcohol more than once a week?

☐ Yes ☐ No

How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Are you currently in a romantic relationship ☐ Yes ☐ No

If yes, for how long? ______________________

What significant life changes or stressful events have you experienced recently?

____

____

____

____

Family Mental Health History

Is there a family history of any of the following? If yes, please indicate the family member's relationship to the client in the space provided.

Example:

Issue	Response	Relationship to Client
Anxiety	X Yes ☐ No	Maternal Grandmother and Mother

Issue	Response	Relationship to Client
ADHD	☐ Yes ☐ No	
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	

Education

What is your highest level of education?

☐ High School/GED ☐ AA /some college ☐ Bachelor's ☐ Master's ☐ Doctorate.

College Major: ______________________________

Additional Information

Are you currently employed? ☐ Yes ☐ No

If yes, where do you work? ___________________________

What is your position and how long have you worked there?

____

Do you enjoy your work? Is there anything stressful about your current work? Please describe.

____

____

Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, please describe your faith or belief. ___________________________

What do you consider to be some of your strengths?

____

____

____

What do you consider to be some of your weaknesses or areas you'd like to improve?

____

____

____

What would you like to accomplish in therapy?

____

____

____

____

____