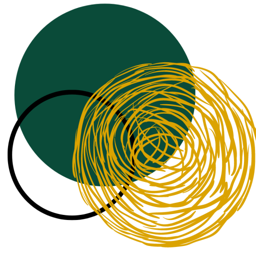

Dr. Mona Shenassa Toubian

REVOLUTIONARY WELLNESS ▪ SOUL WORK EVOLUTION

CLIENT PSYCHOTHERAPY INTAKE FORM

The following questions are designed to help me best meet your treatment needs. If the person seeking care is a minor, the parent of guardian should complete the form. Please bring this completed New Client form and signed Consent for Therapy document with you to our first session. If you have any questions, I will be happy to answer them.

Client Information:

Client's name: ____ Date: _____________

Address: _______________________________________City, State:_________Zip:

Email Address: ____

Phone numbers with area code: Home: ( )_________________Work: ( )________________
Cell: ( )__________________

Birth date: _________________ Age: ____ Social Security Number: _________

Employer: ____

Position: ____________________________________For how long? _____________

Education: ______________________________________

Marital/relationship status: ______________ Significant other's name: _______

Significant other's age and gender: ___________ How long together? __________

Names and ages of all children in the home: ___________________________

Referred by (if any):

Who shall we contact in case of emergency?

Name: ____________________________Phone (   )________________________

Medical and Health History:

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □No □Yes

Previous therapist/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:____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates:____

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

Are you currently experiencing overwhelming sadness, grief or depression?

□No □Yes

If yes, for approximately how long? ________________________

Are you currently experiencing anxiety, panic attacks or have any phobias? □No □Yes

If yes, when did you begin experiencing this? ___________________________

Are you currently experiencing any chronic pain? □ No □Yes

If yes, please describe: ___________________________

Do you drink alcohol more than once a week? □ No □ Yes

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly

□ Infrequently □ Never

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________On a scale of 1-10 how would you rate your relationship?

____

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

Please indicate if you are having any of the following problems, or if you had them in the past:

falling asleep or staying asleep__________

Sleeping too much__________

Change in appetite, weight loss, or weight gain__________

Frequent crying__________

Panic attacks or anxiety attacks__________

Thoughts of killing or hurting myself__________

Attempts to kill or hurt myself__________

Concentrating__________

Problems remembering things__________

Periods of daily sadness lasting more than two weeks__________

I startle easily__________

Can’t stop remembering upsetting past events__________

Difficulty controlling my temper__________

I physically hurt other people__________

I break things sometimes__________

I worry a lot__________

Little or no interest in sex__________

I feel tired almost every day__________

Feelings of unreality__________

Made myself throw up in order to lose weight__________

Used laxatives or exercised excessively to lose weight__________

I often feel like I am an outsider__________

Sexual problems__________

Worry that something is wrong with my body__________

Frequent arguments with the people I live with__________

Other (please list):____

Family Medical and Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, grandmother, uncle, etc.).

Please check the box if applicable:

□Alcohol/Substance Abuse

□Anxiety

□Depression

□Domestic Violence

□Eating Disorders

□Obesity

□Obsessive Compulsive Behavior

□Schizophrenia

□Suicide Attempts

I hereby consent for Dr Mona Shenassa Toubian to provide evaluation and treatment to me.

Signature________________________________Date________________

Print Name________________________________