Claudia Santorelli-Bates, AMFT
Registered Associate Marriage & Family Therapist #105312
PSYCHOTHERAPY
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Name: _____ **Date**: _____

Name of parent(s) / guardian(s)(ifunder 18 years):

_____

_____

Birth Date: / / **Age**: _____ Gender: □ Male □ Female (add other gender)

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ May I leave a message? □ Yes □ No
Cell/Other Phone: _____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

Parent / Guardian Phone: _____ May I leave a message? □ Yes □No
Parent / Guardian Email: _____ May I leave a message? □ Yes □No

Parent / Guardian Phone: _____ May I leave a message? □ Yes □No
Parent / Guardian Email: _____ May I leave a message? □ Yes □No
*{*Please note: Email correspondence is not considered to be a confidential medium of communication.}*

Marital Status: □ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children /age: _____

_____

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner: _____

If some kind of emergency arises and I cannot reach you directly, or I need to reach a person close to you, whom should I call?

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

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: _____

From whom or where do you get your medical care?

Clinic/doctor's name: _____

Date of last physical/medical exam: _____

Phone /Address: _____

If you enter treatment with me, would you like me to contact your medical doctor so that s/he can be fully informed and we can coordinate your treatment? ❑ Yes (complete ROI) ❑ No

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

_____

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

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? _____

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

If yes, when did you begin experiencing this? _____

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

If yes, please describe: _____

8. How many drinks of alcohol do you have each week? _____

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. 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? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

FAMILYMENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following:

	Please Circle	List Family Member
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	_____
Physical / Sexual Abuse	yes/no	_____

Additional Family physical or mental health issues you'd like me to be aware of? _____

_____

If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

_____

How would you describe your relationship with your family? _____

_____

ADDITIONAL INFORMATION:

1. Are you currently employed or in school? □ No □ Yes

If yes, what is your current employment / school situation? _____

Do you enjoy your work / school? _____

Is there anything stressful about your current situation? _____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

_____

4. What do you consider to be some of your weaknesses? _____

_____

5. What would you like to accomplish out of your time in therapy (what do you hope to achieve)? _____

_____

_____

6. Please describe the main difficulty that has brought you to see me: _____

_____

7. **Please describe any issues you would like me to be aware of, including any history of trauma, anxiety, depression, stress, anger, panic, mood swings, ADD, OCD, pain, perfectionism, procrastination, food & body, loss & grief, memory problems, addiction, abuse, neglect, self-harm, self-esteem, suicidal thoughts, relationship problems, sexual problems, financial issues, health issues, legal issues, violence, accidents or illness:**

_____

_____

_____

_____

8. Is there anything else you'd like me to know?

_____

_____