Jerry Moreau, LMFT, CMT
MFT# 52696

2630 1st Ave, Suite 210
San Diego, CA 92103

Client Information

Name: ___________________________________ Date: _____/_____/______

Address: _________________________________ City / Zip: _________________________________

Telephone #: (_____)________________ OK to leave message Y / N

E-mail: ____________________________ OK to contact Y / N
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Date of Birth: _____/_____/_____ Sex: ________________ Occupation:_____________________________

Relationship Status: _____________________________ Partner/Spouse:____________________________

Person to Contact in Case of Emergency:

____________________________________ (_____)_____________ _________________________________

Name Phone Number Relationship to YOU

Are you under a doctor, chiropractor or other health practitioner's care? Y / N
If so, why?____
Are you presently taking any medications / drugs ? _______
If so, List and Why? ____

____

Primary Care Physician Name_____________________________________ Phone ___________________

PAST TREATMENT HISTORY
Psychiatric or psychological treatment of any kind before? YES___ NO___
If Yes, please answer the following:
What type of care was received? Inpatient___ Outpatient___ Both___
When was the treatment?___________________________________
How long was the treatment?________________________________
Name of the therapist or doctor?_________________________
Was there prescribed medication at that time? YES___ NO___ NOT APPLICABLE___
If yes, what was prescribed (include dosages if known)?____

____

Family history of psychiatric treatment:
____

____

____

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On a scale of 1 – 5, how would you rate the following?

NA = the issue does not apply. **1 =** Very Distressed – urgent concern **2 =** Somewhat Distressed
3 = Neither Distressed nor Satisfied **4 =** Somewhat Satisfied **5 =** Very Satisfied

	Please Circle One	Comments
Physical Health	NA 1 2 3 4 5	
Loneliness	NA 1 2 3 4 5	
Friendships	NA 1 2 3 4 5	
Social Support	NA 1 2 3 4 5	
Relation with Family of Origin	NA 1 2 3 4 5	
Relationship with Partner/Spouce	NA 1 2 3 4 5	
Intimacy	NA 1 2 3 4 5	
Sex	NA 1 2 3 4 5	
Career Path	NA 1 2 3 4 5	
Work Environment	NA 1 2 3 4 5	
Income	NA 1 2 3 4 5	
Financial Issues	NA 1 2 3 4 5	
Thoughts of Harming Myself	NA 1 2 3 4 5	
Spiritual Life	NA 1 2 3 4 5	
Depression	NA 1 2 3 4 5	
Anxiety / Worries	NA 1 2 3 4 5	
Sleep	NA 1 2 3 4 5	
Eating	NA 1 2 3 4 5	
Body Image	NA 1 2 3 4 5	
Exercise	NA 1 2 3 4 5	
Alcohol / Drugs	NA 1 2 3 4 5	
Physical Pain	NA 1 2 3 4 5	
Racism	NA 1 2 3 4 5	
Recent Losses	NA 1 2 3 4 5	
Thoughts of Suicide	NA 1 2 3 4 5	
Life in General	NA 1 2 3 4 5	

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How did you hear of my services? ____

If referred by someone, may I thank them? Y / N Initial __________

Why do you seek this work/ what are your goals ?____

____

____

Other information you would like me to know: ____

____

____

____
Client Name

_______________________________________ Date ____/____/____
Client Signature

____
Name of Parent or Guardian (if applicable)

____ Date ____/____/____
Signature of Parent of Guardian (if applicable)