

Jerry Moreau, LMFT, CMT
MFT# 52696

Client Information

2940 4th Ave, #320-3
San Diego, CA 92103

Name: _____

Date: ____/____/____

Address: _____ City / Zip: _____

OK to send mail Y / N

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: ____/____/____ Gender: _____ 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/Spouse	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

Client Signature

Date ____/____/____

Name of Parent or Guardian (if applicable)

Signature of Parent of Guardian (if applicable)

Date ____/____/____