Jerry Moreau, LMFT, CMT
MFT# 52696

# Client Information

3940 4th Ave, #320
San Diego, CA 92103

Name: _____ Date: _____/_____/_____

Address: _____ City / Zip: _____
OK to send mail Y / N

Telephone #: (_____)_____ OK to leave message Y / N - Text 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(s)/Spouse(s):_____

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 | |
| Sexuality | 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)