Meredith Reddoch, MA, LMFT, SEP

License #LMFT84013

1250 Pine Street, Suite 100, Walnut Creek, CA 94596

925.255.5499

meredith@meredithreddoch.com

www.meredithreddoch.com

Therapy for Individuals and Couples

Questionnaire/Intake Form

General:

Name _____ Date_____
Address _____ Phone _____
Work phone _____ Fax _____
E-mail _____ Referred by _____
Age _____ Date of birth _____
Marital status _____ Educational level _____
Occupation _____
Names and ages of children_____
_____
Emergency contact information _____
Explanation of how patient may be contacted by therapist _____
_____

Financial Information:

How do you intend to pay for treatment?(cash, check, Square, Paypal)
_____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____
_____
_____
_____
Do you have any specific goals with regard to your treatment? _____
_____
_____
Do you have any particular concerns/fears with regard to treatment? _____
_____
_____

Psychological History:

Have you ever received mental health treatment before?
_____
When and for how long? _____

What was the focus of treatment?
_____
_____

Name of treating therapist(s), address(es), telephone number(s) _____
_____

Have you ever been subjected to one or more psychological tests?
_____

If so, by whom? _____

Name of person(s) administered psychological tests, address(es), telephone number(s)
_____
_____
_____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long?
_____

Why were you hospitalized?
_____

Name of treating therapist, address, telephone number:_____
_____

Are you currently taking any prescription medications?_____
_____

Prescribed by whom?
_____

How long have you been on the medications? _____

Have you ever taken any medications for a mental or emotional condition?_____
_____

When and for how long?
_____

Have you ever attempted suicide? _____

When?_____

Describe the circumstances that led to that attempt.
_____
_____
_____
_____

Are you currently having any suicidal thoughts? Please describe
_____

_____

_____

Please describe your childhood.

_____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

_____

_____

_____

Have you ever been a victim of a violent crime? Please describe

_____

_____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____

_____

_____

_____

Do you have any medical conditions that may affect your mental health treatment?

_____

Please describe your overall health today. _____

_____

_____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

_____

_____

_____

Have you ever been in a 12-step program? Please describe.

_____

_____

_____

Do you smoke cigarettes? _____ How much? _____ For how long?

_____

Do you drink alcohol? _____

On average, how much alcohol do you consume in a week?_____

Do you currently any other substances? Please describe your use (marijuana, cocaine/crack, meth, hallucinogens, opiates, etc) _____

_____

_____

Have you ever attended residential treatment for substance use issues? Please describe where and when:

_____
_____
_____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother.

_____
_____
_____
_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father.

_____
_____
_____
_____

Names and ages of siblings.

_____
_____
_____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies. _____

_____

Are you now or have you ever been involved in a lawsuit?_____

Please describe. _____

_____
_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.

_____
_____
_____
_____
_____