EMILY HUNTER, LMFT
Licensed Marriage and Family Therapist
www.emilyhuntermft.com 858.255.4898 fax
emilyhuntermft@gmail.com 858.480.5310 phone

PERSONAL INFORMATION Date _____

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone: _____ Birthdate _____ / _____ / _____ Age _____

E-mail _____

Children (names and ages) _____

Siblings (names and ages) _____

Parents (ages or year of death) _____

In case of Emergency, please notify: _____

Relationship: _____ Phone #: _____

MEDICAL INFORMATION

If you are currently under a physician's care, please complete the following:

Physician's Name: _____ Phone #: _____

Reason: _____

If you are currently under a psychiatrist's care, please complete the following:

Psychistrist's Name: _____ Phone #: _____

Reason: _____

Medications currently taking:

Name _____ Amount_____ Date started _____

Name _____ Amount_____ Date started _____

Name _____ Amount_____ Date started _____

Name _____ Amount_____ Date started _____

CURRENT SYMPTOMS

Please indicate below any of the following symptoms you are now experiencing or within the last six months:

___ Difficulty getting to sleep
___ Difficulty staying asleep
___ Excessive sleeping
___ Feelings of sadness
___ Feelings of emptiness
___ Lack of interest in things
___ Significant weight loss or gain
___ Feeling of worthlessness
___ Difficulty controlling drinking alcohol
___ Difficulty controlling drug use
___ Difficulty controlling gambling
___ Difficulty controlling spending money
___ Anorexia
___ Bulimia
___ Binge or emotional eating
___ Very strong startle response
___ Increase/Decrease of appetite
___ Feeling of excessive guilt
___ Crying easily or frequently
___ Easily angered, irritable
___ Excessive Fears
___ Difficulty expressing anger
___ Sudden decreased need for sleep
___ Pressure to keep talking
___ Difficulty concentrating
___ Unusual indecisiveness
___ Recurrent thoughts of death
___ Plan to commit suicide
___ Suicide attempt
___ Feelings of helplessness
___ Excessive worries & anxieties
___ Fear of going crazy
___ Excessive Nightmares
___ Fear of socializing with people
___ Sudden feeling of dizziness
___ Sudden numbness or tingling
___ Repetitive behaviors that are difficult to stop
___ Tearfulness
___ Difficulty controlling anger
___ Sudden pounding of heart
___ Sudden sweating
___ Sudden trembling or shaking
___ Sudden feeling of shortness of breath
___ Thoughts racing
___ Easily Distracted
___ Increased need to get things done
___ Recurrent & persistent intrusive thoughts

LIFESTYLE

_____ Hours of sleep on average

_____ Bedtime

_____ Wake time

_____ Hours of weekly exercise or physical activity

_____ Minutes of Meditation/Reflective practice per week

_____ Minutes of sunlight per day

_____ Number of pleasurable experiences per week

_____ Minutes of isolative activities per day (t.v., video games, reading)

_____ Alcohol consumption per week

_____ Do you smoke (cigarettes, marijuana, other)? How much?

_____ Non prescribed drugs (cocaine, meth, ecstasy, oxycontin, other)

RELATIONSHIPS

Please indicate what applies to you:

Marital history: ☐ Never ☐ Married once ☐ Married twice ☐ Married more than twice

Abuse by parent: ☐ physical ☐ sexual ☐ emotional ☐ neglect

Abuse by partner: ☐ physical ☐ sexual ☐ emotional ☐ neglect

Abuse by healthcare professional or employer: ☐ physical ☐ sexual ☐ emotional

_____

HOW DID YOU FIND ME?

Friend _____ Physician _____ Therapist _____ Other _____

Veteran's Service Branch: ☐ Army ☐ Navy ☐ USAF ☐ USMC ☐ USCG ☐ Other

COUNSELING PROBLEM AND GOALS

Please describe the problem(s) for which you are seeking counseling:

_____

_____

How long has this been a problem?

_____

_____

What do you hope to obtain from counseling?

_____

_____

Have you had counseling in the past? If so, was this counseling helpful? Please explain.

_____

_____

_____

Is there anything else you wish me to know prior to our working together?

_____

_____

ACKNOWLEDGEMENT OF INFORMED CONSENT

By my signature below I, _____ , acknowledge that I reviewed a copy of the Informed Consent and agree to the terms.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

_____ _____

Signature of Emily Hunter, LMFT Date