April Wright, M.A., LMFT
Lic. MFC96155
310) 502-4944

Initial Interview Form

Name:_____ **Gender:**_____

Home Address:_____

_____

Phone:_____**Message OK:** Yes____No

Alternate Phone:_____**Message OK:** Yes____No

_____

Email Address:_____

Age:_____ **Date of Birth:**_____/_____/_____ **Birth Place:**_____

Relationship Status:_____

Sexual Orientation: _____

Education level:_____

Occupation: _____

Emergency Contact:_____

Relationship to You:_____

Emergency Contact Phone:_____ **Alternate Phone:**_____

Please list names and ages of siblings, if any:

Please describe briefly what brings you into counseling:_____

Symptoms/Chief Complaints:

	Good	Fair	Poor		Yes	No		Yes	No
Sleep:	( )	( )	( )	**Restless:**	( )	( )	**Nightmares:**	( )	( )

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Appetite:	**( )**	**( )**	**( )**	**Weight loss:**	**( )**	**( )**	**Weight gain:**	**( )**	**( )**
Energy level:	**( )**	**( )**	**( )**	**Low energy:**	**( )**	**( )**	**Hyper:**	**( )**	**( )**
Attention level:	**( )**	**( )**	**( )**	**Crying Spells:**	**( )**	**( )**	**Sadness:**	**( )**	**( )**
				Depression:	**( )**	**( )**	**Anxiety**	**( )**	**( )**

	Yes	**No**
Suicidal thoughts:	**( )**	**( )**
Homicidal thoughts:	**( )**	**( )**

Have you ever experienced these thoughts previously? [ ] Yes [ ] No

If so, when and how did you cope?

Have you ever physically harmed anyone? [ ] Yes [ ] No

If yes, please explain:

Have you ever been arrested for a crime? [ ] Yes [ ] No

If yes, please explain:

Has anyone in your immediate and extended family been diagnosed with a psychological or emotional problem? [ ] Yes [ ] No

If yes, please specify:

Has anyone in your immediate and extended family had a substance abuse problem?
[ ] Yes [ ] No

If yes, who, what substance(s), and duration?

Have you ever been in psychotherapy/counseling before? [ ] Yes [ ] No

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If yes, specify dates and type:

What did you like most about therapy?

What did you like the least?

Have you ever been hospitalized for psychological/emotional difficulties, eating disorder(s), alcohol/drugs, surgery or childbirth(s)? [ ] Yes [ ] No

If yes, specify dates and reason:

Has any physician ever prescribed medication for psychological problems/emotional difficulties or eating disorder(s)? [ ] Yes [ ] No

If yes, specify physician's name, dates, duration of use, and type of medication:

Are you currently using any prescribed or non-prescribed medication?

[ ] Yes [ ] No

If yes, name of medication, dosage and reason prescribed:

What are the 3 main areas of stress/ concern in your life?

Please list 4 goals for therapy