Joan Pechauer, LMFT

Date:_____

Name (s): 1_____
Last First MI

2_____
Last First MI

Address:_____
City State Zip

Home phone:_____ Birthdate(s): 1_____2_____

Cell phone: _____

Occupation(s):_____ _____

Business phone: 1_____ 2_____Is it all right to call you there? _____

Your primary care physician: _____ Phone:_____

Are you currently in therapy? _____

Person who referred you: _____

Who lives in your household?

Name	Age	Relationship to you
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please answer the following questions from your personal perspective.

1. Who referred you to Joan Pechauer, LMFT?

_____

2. What is the crisis or problem that brought you to see Joan?

_____
_____
_____

Problem List

Listed below are possible problems you or your family may have now. Please rate each by your degree of concern by circling the issue, number and why.

1. Suicide potential or Depression (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____
_____

2. Alcohol/drug abuse (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____
_____

3. Family/Relationship Conflict (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____
_____

4. Worry/anxiety (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____
_____

5. Verbal abuse/behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____

6. Sexual abuse/behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____
_____

7. Physical abuse/behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Why?

_____
_____
_____

8. Other problem/behavior (Low) 1 2 3 4 5 6 7 8 9 10 (High)
   Name and
Why?_____
_____
_____

Assessment

Why do you think there are these problems for you or your family?

_____
_____
_____
_____

Problem Solving

What is the main goal or need you have for the first session?

_____
_____
_____

What are your ideas on how that goal can be accomplished?

_____
_____
_____
_____
_____