Yoshimi Enger, MFC 43521
Licensed Marital and Family Therapist
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(949) 412-4381

CLIENT INFORMATION

Date:_____20___ Referred by (please be specific):_____
Client Name:_____ DOB:_____
Address:_____
Street City Zip
Phone: Home:_____ Cell: _____ Work:_____
Email:_____
Circle one: Single/Married/Div/Wid Other:_____
Children?: No ☐ Yes ☐ Names and Ages_____
_____
Employer _____Occupation: _____
Work Address: _____
Household income per year: $_____
Primary Care Doctor_____ Phone: _____
Hospital: _____Address: _____
In Case of Emergency:
Name: _____ Relationship:_____ Phone: _____
Name: _____ Relationship: _____ Phone:_____

Why are you or your child seeking treatment? What is the main problem?_____
_____
_____
_____

Insurance: _____ Insured Name:_____
Relation to Insured: Self / Spouse / Child
Insured DOB: _____ Insured Address: _____

Previous Therapy, if any (please provide name, reason for treatment and how long you attended):
Name of Therapist: _____ Dates: _____to_____
Medications: Type: _____Dosage: _____
Type: _____Dose: _____Type: _____Dose:_____
**Additional Medications on back of page*
Have you been convicted of a crime? ☐ Yes ☐ No Describe: _____
Have you been court ordered to seek counseling? ☐ Yes ☐ No Describe: _____
_____

****For Child Clients Only****
Parent/Guardian: _____ Relationship: _____
_____ Relationship: _____
If Divorced/Guardian who has LEGAL CUSTODY, not physical custody: _____

Note: Please provide documents of proof of legal custody

Please Check any of the following that apply:

1. Life feels out of control	☐
2. Cannot do usual activities	☐
3. Suicidal thoughts	☐
4. Suicide attempts (recent)	☐
5. Deterioration of relationships	☐
6. Thought of hurting others	☐
7. Physically have hurt others	☐
8. Isolated, withdrawn	☐

Past Psychiatric History

Please indicate any prior residential placement and/or hospitalization for alcohol, drug, or emotional problems:

Date Admitted:
Date Discharged:
Duration:
Age:
Medications:
Primary reasons: Use codes below

Have you ever made a suicide attempt? (Describe)

Do you have an eating disorder? (Anorexia, Bulimia, Disordered eating etc.)

Have you ever tried to physically hurt yourself? (i.e. cut yourself, hit yourself with intention to hurt, burn yourself with cigarettes, etc.) Describe

Exclusively Heterosexual ☐	Nonsexual ☐
Primarily Heterosexual/Some Homosexual ☐	Bisexual ☐
Primarily Homosexual/Some Heterosexual ☐	Exclusively Homosexual ☐

Sexual Preference

Social and Developmental History

Where were you born?
Where were you raised?
Who were the primary people present in your home while you grew up?
Describe your job (how long at same place and for whom do you work) ?
What sort of work have you done in the past?
Current living arrangements: Alone ☐ Room mate(s) ☐ Parents/Relatives ☐ Spouse ☐
What are your hobbies?
Religion:

Medical History

Do you have a medical doctor?
Name:
Address:
Telephone:
Allergies:
Past Surgery (ies):
Number of Pregnancies:
Serious medical problems:

Substance abuse

Do you use alcohol?	How much?
What kind of alcohol?	
Do you use recreational drugs?	How much?
Which ones?	
Do you feel that you have ever had an alcohol or drug problem?	
Extreme ☐ Very Much ☐ Moderate ☐ Slight ☐ Not at all ☐	
Do you exercise regularly?	How often?
What kind of exercise?	

Additional Information

Have you ever been abused physically, sexually, or psychologically? Please describe.

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

AREAS	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/ Relationship						
Family						
Job/ School Performance						
Friendships						
Hobbies						
Financial Situation						
Physical Health						
Mood						
Eating Habits						

OVER THE LAST TWO WEEKS HAVE YOU EXPERIENCED:

AREAS	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Feeling irritable or on edge						
Unrealistic or excessive worry						
Loss of interest in activities						
Problems due to drugs/alcohol						
Difficulty controlling anxiety/worry						
Sleeping more or less						
Fatigue or loss of energy every day						
Unable to concentrate						
Muscle tension						

The information provided above is true and complete to the best of my knowledge. I understand that if I have misrepresented myself or provided false information, it can lead to the termination of the therapeutic relationship and or other adverse effects.

_____

Signature Date

_____

Signature Date