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### New Client Information

Your answers to these questions will give me a quick view into a spectrum of parts of your life. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments. I encourage you to bring up any areas I haven't asked about.

Name: \_\_\_\_\_ Pronoun: \_\_\_\_\_

Legal name (if different): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Present

Address: \_\_\_\_\_  
*Street City State Zip*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Who do you authorize me to contact and disclose any necessary information to ensure your safety in an emergency?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Cell) \_\_\_\_\_ (Home/Work) \_\_\_\_\_

Please describe medical care you are receiving, including any medications you take:

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Please briefly describe what led to your choice to work with me.

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What do you hope to come from our work together?

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Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

**0**      **1**      **2**      **3**      **4**      **5**      **6**      **7**      **8**      **9**      **10**  
**No**    **Minimal Concern**                      **Moderate Concern**                      **Extreme Concern**

\_\_\_\_\_ Anger/aggression

\_\_\_\_\_ Sexual orientation

\_\_\_\_\_ Religious/spiritual

\_\_\_\_\_ Gender identity/transition

\_\_\_\_\_ Depression/feeling sad

\_\_\_\_\_ Loved one's drug/alcohol use

\_\_\_\_\_ Sex/intimacy

\_\_\_\_\_ Partnership/dating/relationship

\_\_\_\_\_ Impacts of abuse/violence/trauma

\_\_\_\_\_ Nervousness/Anxiety

\_\_\_\_\_ Thoughts of suicide

\_\_\_\_\_ Physical/health/disability

\_\_\_\_\_ Eating or body image

\_\_\_\_\_ Work/employment

\_\_\_\_\_ Feeling frozen/numb/vacant

\_\_\_\_\_ Social relationships/friends

\_\_\_\_\_ Fearfulness

\_\_\_\_\_ Relationship(s) with family

\_\_\_\_\_ Unhappy most of the time

\_\_\_\_\_ Grief/loss

\_\_\_\_\_ Sleep

\_\_\_\_\_ Finances

\_\_\_\_\_ Use of alcohol/drugs

\_\_\_\_\_ Other (specific)