Janie Sheedy, Licensed Marriage and Family Therapist

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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status\_\_\_\_\_\_\_\_Name of Spouse/Partner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Info\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Children\_\_\_\_\_\_\_\_\_\_\_\_Names and Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to Contact in an emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faith Base or Religious Beliefs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information and History:**

Name of Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Medical Examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a doctor’s care? (Yes) (No) If yes, doctor’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for doctor’s care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is your physical health at present? (Poor) (Unsatisfactory) (Satisfactory) (Good) (Very Good)

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, thyroid, etc):

Have you ever been hospitalized for a physical illness? (Yes) (No)

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you regularly use alcohol? (Yes) (No)

If yes, in a typical month, how often do you have 2 or more drinks in a 24-hour period?

Do you engage in recreational drug use? If so, how often?

(Daily) (Weekly) (Monthly) (Rarely) (Never)

Are you currently under the care of a psychiatrist? (Yes) (No)

Are you currently taking anti-depressant medication? (Yes) (No) If yes, please list:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication | Dosage | Reason Prescribed | When Prescribed |
|  |  |  |  |
|  |  |  |  |

Have you had any previous therapy/counseling? (Yes) (No)

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Therapist | Phone/Contact Info. | Dates of Therapy | Number of Sessions |
|  |  |  |  |
|  |  |  |  |

Please provide a brief description of type(s) of therapy you have received:

**Description of Presenting Problems**

Please list any current difficulties you are experiencing below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Depression/sadness |  |  | Difficulty sleeping |
|  | Suicidal thoughts |  |  | Loss of appetite |
|  | Recurrent/intrusive thoughts |  |  | Weight gain |
|  | Anxiety/nervousness |  |  | Significant weight loss |
|  | Palpitations, pounding heart |  |  | Fatigue or loss of energy |
|  | Trembling or shaking |  |  | Difficulty concentrating |
|  | Dizzy or light-headed |  |  | Nightmares |
|  | Numbness/tingling sensations |  |  | Loss/interest in pleasurable activities |
|  | Excessive fears/phobias |  |  | Feeling completely hopeless |
|  | Fear of dying |  |  | Feelings of worthlessness |
|  | Flashbacks of a traumatic event |  |  | Feeling completely helpless |
|  | Feeling hypersensitive/hyper-arousal |  |  | Extreme anger |

Please state in your own words the nature of your primary problems:

On the scale below, please estimate the severity of your problem(s):

Mildly upsetting\_\_\_\_\_ Moderately upsetting\_\_\_\_ Very severe\_\_\_\_ Extremely Severe\_\_\_\_ Incapacitating\_\_\_\_

When did your problems begin?

What seems to worsen your problems?

What have you tried that has been helpful?

**Expectations Regarding Therapy**

Is there anything I should know about you that you believe would be important to the work we will be doing together?

What are your goals for therapy?

In what ways do you hope your life would improve if therapy were successful?