**Joey Downey, LMFT, MFC #41874**

**Website: joeydowneylmft.com**

**E-mail:** [**joey@joeydowneylmft.com**](mailto:joey@joeydowneylmft.com)

**Phone: 707. 329.3226**

**Client Information**

1. What are your current symptoms (issues) that you are experiencing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How long have the symptoms (issues) been occurring?

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3. Have there been any major changes at work or at home? Yes No If yes, please explain below

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4. Are you currently receiving any therapy/medical treatment? Yes No If yes please answer below

Where is the current place of treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have you received any previous therapeutic/psychological treatment? Yes No If yes please answer below

What were the reason(s) for the treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6. Have you ever been prescribed or currently on any psychotropic medication? Yes No If yes please explain below

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7. Are you experiencing any thoughts of self-harm? Yes No

8. Harm to others? Yes No

9. Are you exhibiting any of the following symptoms?

Fatigue Yes No Hearing Voices Yes No Sexual Acting Out Yes No

Lying Yes No Bed Wetting Yes No Stomach Problems Yes No

Worries Yes No Poor Appetite Yes No Difficulty Sleeping Yes No

Anxiety Yes No Change in Mood Yes No Poor Concentration Yes No

Hyperactivity Yes No “Sleep Walking” Yes No Bowel Problems Yes No

Stealing Yes No Unusual Fears Yes No Nightmares/Bad Dreams Yes No

Frequent Anger Outbursts Yes No

If you answered yes to any of the previous questions please give more details in the space below.

10. Please list below any other concerns you have?

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11. What would you like to get out of coming to therapy?

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