Feel Better Counseling

Kathleen Jeanne Troncao-Heath; Licensed Marriage & Family Therapist; LMFT#77993

Client Intake

Date___________

Name ____

Address: ______________________________________City: ____________State: __ Zip:_______

Phone Home ___________________ Cell ______________ Work ___________________

Age _____________ Date of birth ___________________

Educational level ____________ Occupation ________________________ Referred by ____________________

Marital status ___________________________ Spouse/Partner ______________________________________

Emergency contact information ____

Therapist Communications

Therapist may contact me using the following.

____Home phone ____ Cell phone ____Work phone.

May therapist text to confirm or change scheduled appointments? Yes No

____My therapist may send mail to me at my home address

____My therapist may send mail to me at this address. ____

Do you need a Superbill to submit to your insurance company: Yes No

Areas of Concern

What issues/concerns caused you to seek treatment? Please describe.

____

Goals for counseling. ____

Health History:

Have you ever received mental health treatment before? ___ Yes ___ No

Have you ever been hospitalized for mental or emotional problems? ___ Yes ___ No

Are you currently taking any prescription medications? ______ (If so, please list below.)

Medication	Dosage	Frequency	Purpose	Date began	Physician

Have you ever attempted suicide? Yes No

Are you currently having thoughts of suicide or harming yourself? Yes No

Are you currently having thoughts of harming someone else? ___ Yes ___ No

In the past 6 months have you experienced any of the following: Please circle.

depressed mood anxiety sleep difficulties change in appetite headaches body ache/pain

difficulty concentrating racing thoughts rapid heart bead hopelessness low energy

Have you ever been diagnosed with a serious or ongoing illness? ___ Yes ___ No

Please describe your overall health today Good Fair Poor

Family Information

Children

Name Age Living with you? Relationship (good/poor)

____

____

____

____

Siblings

Name Age Relationship (good/poor)

____

____

____

____

Parents

Mother's name Age Relationship (good/poor)

____

Father's name Age Relationship (good/poor)

____

Step-Mother Age Relationship (good/poor)

____

Step-Father Age Relationship (good/poor)

____

Names and ages of people living in your home

____

____

____

Other Information

Please describe your spiritual identity/orientation. ______________________________________

Please describe your interests/hobbies ______________________________________

Are you a member of the military? Yes ____ No _____

Are you now or have you ever been involved in any type of legal matters? ______________________

Please describe. ______________________________________

Other relevant information, not previously requested. ______________________________________

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