

CONFIDENTIAL

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The answers to these questions are to assist in providing care. **THIS FORM IS CONFIDENTIAL**

Name: _____ Date: _____

Birth Date: _____ Marital Status: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Can I leave a message for you? at Home? Y / N • at Work? Y / N

Sex: M / F • Age: _____ • Do you have health insurance? Y / N • Do you wish to use insurance? Y / N

Insurance Information: _____

Who referred you? _____

With whom do you presently live with? _____

Is this working for you? _____

What brought you here today? _____

What are your goals for counseling? _____

Do you have any fears or concerns about being in counseling? _____

Are you experiencing stress in any of these areas?

Grief: _____ Financial: _____

Work: _____ School: _____

Relationships: _____ Family: _____

Legal: _____ Other: _____

Who are the people you feel emotionally supported by?

Family: _____ Friends: _____

Spirituality: _____ School: _____

Work: _____ Professionals: _____

What is your uses of substances? (approximately)

Substance	Amount	Frequency	Last use
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Alcohol: _____

Prescription: _____

Recreational Drugs: _____

Other: _____

Do you have a history of Seizures ____ Hallucinations ____ Blackouts ____ Scary Thoughts ____
Confusion ____ Tremors ____ Other: _____

Previous Counseling Experience – Outpatient / Inpatient

With Whom: _____ Where: _____ Diagnosis: _____ Frequency: _____

Are you currently working with any other doctor, therapist, psychologist, group, etc.? Y / N
If Yes, explain: _____

May I contact them? Y / N Name: _____ Phone: _____
Y / N Name: _____ Phone: _____

Have you taken any psychotropic medications in the past at any time?
Antipsychotics: _____ Antidepressants: _____ Antianxiety: _____

Medical History

Current Medical Problems: _____

Name of Physician: _____

Could I contact them to coordinate your care, if necessary? Y / N Phone: _____

Are you currently taking any medications?	For What	Dosage
_____	_____	_____
_____	_____	_____

Have you experienced any of the following in the past year?

- [] Fatigue / Sleep Disturbance: _____
- [] Depression / Extreme Sadness: _____
- [] Loss of Interest in Daily Activity: _____
- [] Panic / Anxiety: _____
- [] Decreased Concentration / Memory Loss: _____
- [] Mood Swings: _____
- [] Weight Gain / Loss: _____
- [] Excessive Worthlessness / Guilt: _____
- [] Paranoia / Obsessive Behavior: _____
- [] Isolation / Loneliness: _____

Have you ever attempted or seriously considered suicide? _____
When? _____

Have you ever engaged in self-mutilation/cutting/burning? Y / N Specify how? _____

Have you any concerns about your sexuality with your partner or for yourself? Y / N
Any: Heart palpitations [] Difficulty breathing [] Stomach problems [] Diabetes [] Other []

Any disabilities including visual / auditory Y / N Describe: _____

Do you wish to have your religious/spiritual beliefs and values incorporated into therapy? Y / N