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Welcome!

The information you provide will be kept strictly confidential.

Today's Date _____

General Information

Name _____ Date of Birth _____ Age _____ Sex: M F

Address _____
(Street) (City) (State) (Zip)

Phone: Home (____) _____ Work (____) _____

Cell (____) _____ OK to leave message? Y / N Text? Y / N

Email address _____

Occupation _____

Employer _____ Length Employed _____

Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

If married, years wed? _____ If previously married, years wed? _____

Name of Spouse _____ Spouse's Date of Birth _____

Spouse's Occupation & Employer _____

Emergency Contact

Emergency Contact: _____ Relationship _____

Phone: _____ Address: _____

Please list the people who currently live with you:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Name of personal physician _____

Physician phone #: _____

Date of last medical exam _____

List important illnesses, injuries, or disabilities, past and present:

Are you presently taking medication? Y / N

If so, list name(s) and dosage _____

Prescribing Physician: _____

Mental Health History

Have you ever received counseling before? Y / N If yes, when? _____

Name of Previous Counselor: _____

Have you been given a previous mental health diagnosis? _____

Please share what your previous experience was like with counseling:

Have you ever been hospitalized for mental/emotional difficulties? Y / N

If yes, give dates and reason:

Has anyone in your family ever had an emotional or mental health problem? Y / N

If so, please explain: _____

Have you or any family members ever been suicidal, made a suicidal attempt, or committed suicide? Y / N Please explain: _____

Substance Use

Do you drink alcohol? Y / N Amount/frequency _____

When did you begin drinking? _____

Do you smoke cigarettes? Y / N Amount/frequency _____

When did you begin smoking? _____

Do you smoke marijuana or use any other drugs? Y / N If yes, what substances? _____

Amount/frequency _____ When did you begin using? _____

Have you ever received treatment for any substance abuse? Y / N If yes, when and where: _____

Do any family members have a history of substance abuse? Please explain: _____

Legal History

Please list any present or past history of arrest, court involvement, or other legal problems:

History of Violence/Domestic Violence/Abuse/Trauma

Do you have a history of violence? Y / N Briefly explain: _____

Do you have a history of domestic violence? Y / N Briefly explain: _____

Have you ever been physically, emotionally, or sexually abused? Y / N Briefly explain: _____

Have you experienced anything else in your life that you consider traumatic? Y/N

Briefly explain: _____

Educational/Occupational History

What is your level of education: _____

What jobs have you held in the past 10 years: _____

Religion/Spirituality

Do you have a religious or spiritual orientation? _____

If so, what is your religious/spiritual practice: _____

Is religion/spirituality important in your treatment? Y / N

Culture

Ethnicity: _____

Place of birth: _____

Languages spoken: _____

Is there anything you would like therapist to know about your culture? _____

Current Problems

Briefly describe the problem(s) for which you are seeking treatment:

On the scale below, please circle the most accurate description of the severity of your problem(s):

mild moderate difficult severe

When did the problem(s) start? _____

Please list three hopes/ expectations for counseling at this time:

- 1) _____
- 2) _____
- 3) _____

Any other information that would be helpful for the therapist to know at this time?

I, _____, verify that the above information is true and correct.

(Client Signature)

(Date)

(Parent/Guardian Signature)

(Date)