COUNSELING SERVICES Deborah Wieland, M.S. LMFT # 96864 714-408-3702
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NPI # 1902014145

**New Patient Information**

Client Name:_____ Today's date:_____

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

Address:_____

City:_____ Zip:_____

Cell:_____ Email address:_____

Marital Status:_____ Spouse's Name:_____

Children's Names/Ages:_____

Employer:_____ Occupation:_____

Presenting Issue/Reason Seeking Therapy:_____

_____

Referred By:_____ Primary Care Physician:_____

Phone:_____ Date last seen:_____

Current Medication and taken for:_____

Current & Past Medical Conditions, Surgeries:_____

Emergency Contact:_____ Phone:_____

Parent Name: _____ Name:_____

Address:_____ Cell: _____

**Assessment of Life Functioning**

Please select how your emotional status or issues have affected the following areas (Circle Choice Below).

| | No Effect | Low Effect | Some Effect | Much Effect | High Effect | N/A |
|---|---|---|---|---|---|---|
| Marriage/Relationship | 1 | 2 | 3 | 4 | 5 | N/A |
| Family | 1 | 2 | 3 | 4 | 5 | N/A |
| Job/School Performance | 1 | 2 | 3 | 4 | 5 | N/A |
| Friendships | 1 | 2 | 3 | 4 | 5 | N/A |
| Financial Situation | 1 | 2 | 3 | 4 | 5 | N/A |
| Hobbies | 1 | 2 | 3 | 4 | 5 | N/A |
| Physical Health | 1 | 2 | 3 | 4 | 5 | N/A |
| Anxiety/Nerves/Worry | 1 | 2 | 3 | 4 | 5 | N/A |
| Depressed Mood | 1 | 2 | 3 | 4 | 5 | N/A |
| Eating Habits | 1 | 2 | 3 | 4 | 5 | N/A |
| Sleeping Habits | 1 | 2 | 3 | 4 | 5 | N/A |
| Sexual Functioning | 1 | 2 | 3 | 4 | 5 | N/A |
| Ability to Concentrate | 1 | 2 | 3 | 4 | 5 | N/A |
| Ability to control Anger | 1 | 2 | 3 | 4 | 5 | N/A |
| Spirituality | 1 | 2 | 3 | 4 | 5 | N/A |
| Children/Parents | 1 | 2 | 3 | 4 | 5 | N/A |

Any Family History of Psychological or Medical Conditions:_____

_____

Personal History of Psychological or Medical Conditions: _____

_____

Have you or are you receiving psychiatric or psychological treatment? Yes □ No □

If yes: What type of cared did you receive? Outpatient □ Inpatient □ Both □

Dates had treatment:_____ Describe what you liked/disliked about treatment: _____

_____

List hobbies, personal enjoyment leisure activities::_____

_____

Who takes care of you when you are sick:_____

List any trauma, Legal or addiction issues:_____

_____