

COUNSELING SERVICES

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New Patient Information

10061 Talbert Ave, Ste 200 Fountain Valley CA 92708

Tax ID: 83-1351896 NPI # 1245776681

Patient 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 care 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: _____