Christine Pilcher, MA
MFT Registered Intern #75958

Valencia Therapy Services
25000 Avenue Stanford #231
Valencia, CA 91355
661.724.6041

Supervised and employed by James Walsh
LMFCC #21963, LAADC #1651013
661.513.3876

Client Information

Name: _____ Date of birth: ____/____/___Age:_____
Address: _____ City/Zip: _____
Phone: Home_____OK to call? Y/N Work_____OK to call? Y/N
Mobile_____OK to call? Y/N Other_____OK to call? Y/N
Email: _____ Emergency contact:_____

Partner/spouse's name: _____ Date of birth: ____/____/___Age:_____
Address (if different): _____
Phone: Home_____OK to call? Y/N Work_____OK to call? Y/N
Mobile_____OK to call? Y/N Other_____OK to call? Y/N

Occupation, employer, and current number of hours worked per week:
You: _____
Employer Address: _____
Partner/spouse: _____
Employer Address: _____

Please list the names, ages, sex, and relationships of all those in your current household:

_____

_____

If you or your partner/spouse have children not living with you, please list their names, ages, sex, and locations: _____

_____

Your highest educational level: _____ Partner's/spouse's: _____
What health, allergies or medical problems do you or other family members have?_____

_____

_____

_____

Which medications and dosages are you taking? _____

_____

_____

_____

Who is your physician (address/phone)? _____

_____

Do you have a health care directive? Y/N If no, did you receive an advanced health care directive fact sheet? Y/N

Do you have insurance you will be using to pay for therapy? (If so, please provide name, address, phone number, policy number, and contact person): _____

_____

What is the main issue for which you are seeking help? _____

_____

What service are you specifically requesting of this therapist? _____

_____

How have you attempted to deal with this problem thus far (please be brief and specific)?

_____

_____

_____

Have you had therapy or counseling before? Please list dates and name and location of provider(s):

_____

_____

_____

If so, what was the nature of the therapy? _____

_____

Was it helpful to you? _____

If not, why not? _____

_____

Have you ever been in trouble with the law? Describe incident and give approximate dates. What was the court disposition? _____

_____

Are you currently on probation? If yes, list probation officer and what is his/her phone number?

_____

Is there any legal action currently pending? If yes, what? _____

_____

Do you have an "open case" with the Department of Children Services? Y/N If yes, Please give the name of the social worker and explain the nature of your case_____

_____

Has any of your children been placed in a foster home? Y/N If yes, please explain_____

_____

Please make any other comments you wish, including critical events that have occurred in your family or anything special or unique about your family or other individuals you want the therapist to know about:_____

_____

_____

Referral source: _____Address: _____Phone: _____

Check "yes" if the problem affects your life. Check "no" if the problem does not affect your life. Check "sometimes" if you have the problem occasionally.

	Yes	No	Sometimes	Comments
Mood swings				
Behavior problems (Specify)				
Nervousness				
Suicidal notions / attempts				
Homicidal notions / attempts				
Depression				
Anxiety				
Weight loss/gain				
Destructive (to self or property)				
Lying				
Health problems diagnosed (Specify)				
Health problems undiagnosed (Specify)				
Easily angered				
Eating (too much / too little)				
Lack of interest in friends				
Tiredness / Lack of energy				
Lack of interest in favorite activities				
Fears (List them), phobias				
Sleeping (too much / too little)				
Memory difficulties				
Marital problems				
Relationship problems				
Fighting				
Communicating with people				
Stealing				
Legal problems (specify)				
Substance (Alcohol,drug,other) abuse (specify)				
Substance (Alcohol,drug,other) addiction (specify)				
Caffeine or nicotine overuse				

	Yes	No	Sometimes	Comments
Pornography addiction				
Work problems				
Relationship with children				
Relationship with parents				
Relationship with other(s) (Specify)				
Divorce / separation				
Death of a love one				
Death of a friend				
Sexuality concerns				
Sexual problems / abuse				
Physical abuse				
Financial problems				

Check "yes" if the problem affects your life. Check "no" if the problem does not affects your life.
Check "sometimes" if you have the problem occasionally.

	Yes	No	Sometimes	Comments
Lack of concentration, confusion, indecision				
Over activity, mania				
Nervousness, excessive worry				
Thought disorganization and confusion				
Parenting problems				
Social problems				
Temper problems				
Violence against others (physical harm of any kind)				
Learning or school problems				

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Please comment on anything else you wish: _____
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