Carol A Kaye, MFT

8950 W. Olympic Blvd., Suite 192
Beverly Hills CA 90211

Please provide the following information and answer the questions below. **Please note: the information you provide here is protected as confidential.

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ **Age:** _____ **Gender: □ Male □ Female**

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Name of Partner or Spouse: _____

Client's Home Address: _____
(Number and Street)

_____
(City) (State) (Zip)

Home Phone: _____**OK to leave a message? □ Yes □ No**

Cell Phone: _____ **OK to leave a message? □ Yes □ No**

E-mail: _____**OK to email you? □ Yes □ No**

Please note: Email correspondence is not considered to be a confidential medium of communication.

Employer's Name and Phone: _____

Emergency Contact: _____

Relationship to Client: _____**Phone:** _____

Referred by (if any):_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services,etc.)?

□ No
□ Yes, previous therapist/practitioner: _____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. Please list any difficulties you experience with your appetite or eating patterns

_____

4. Are you currently experiencing overwhelming sadness, grief or depression?

□ No
□ Yes

If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No
□ Yes

If yes, when did you begin experiencing this? _____

6. Are you currently experiencing any chronic pain?

□ No
□ Yes

If yes, please describe _____

7. What significant life changes or stressful events have you experienced recently:

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

What would you like to accomplish in therapy?

_____

_____

_____