Roxanne Strauss Therapy, 4700 Spring St., #204, La Mesa, CA 91942

Client Information

If there are any questions that you would rather not answer in writing, just leave them blank and we can discuss them in session when you are ready. All information provided is confidential.

General Information

Client Name: _____ Date:_____

Age:_____ D.O.B.:_____ Occupation_____

Employer/School:_____

Home Address:_____

Primary Phone _____ Secondary Phone_____

May I leave a message for you at (please circle): Primary phone and/or Secondary phone

Marital Status: Married Remarried Single Single Parent Widow(er) Divorced Separated Partnered

If Applicable, Spouse's Name:_____

Do you have any children? Yes or No

If yes, Names and Ages:_____

_____

Who lives in your home?_____

Permanent Address (same as above____) _____

_____

Emergency Contact name and phone #:_____

_____

May I contact you via email or via text messaging to discuss scheduling and other related issues?
Email: Yes or No

E-Mail: _____

Text Messaging: Yes or No

How did you hear about Roxanne Strauss, LMFT?

If applicable, may I thank your referral source? Yes No

Areas of Concern

What issues or concerns bring you to therapy today?

What are your goals for therapy? What do you hope to receive from therapy?

Do you have any concerns regarding therapy?

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)?
Yes or No

If yes, when and for how long?

Please briefly describe the reasons:

Medical Information

Are you currently taking any medications? Yes or No

Please list all medications:

How long have you been taking the medications?

If you are taking prescription medications, who is the prescribing physician?

Have you ever been diagnosed with a serious illness? If yes, please describe.

At any time in your life, have you experienced any bodily injuries needing medical treatment (for example, head injury or concussion, broken bones, etc)? If yes, please explain.

How would you describe your overall health?

Do you smoke tobacco cigarettes, vapor cigarettes, or cigars? Yes or No

If yes, how much? _____ For how long? _____

Do you smoke/use marijuana? Yes or No

If yes, how often do you smoke/use marijuana in a week? _____

Do you drink alcohol? Yes or No

On average, how much alcohol do you consume in a week? _____

Do you take illegal drugs? Yes or No

Family of Origin History

Please briefly describe your childhood:

Are your parents living or deceased? Mother _____ Father _____

Do you have stepparents? (please circle) Stepmother Stepfather

If applicable, are your stepparents living or deceased? Stepmother _____ Stepfather _____

Names and ages of siblings:

Other Information

Please describe your spiritual identity/orientation:

Do you wish to incorporate your spiritual identity into your therapy? Yes or No

Please describe your interests/hobbies:

Are you now or have you ever been involved in a lawsuit? Yes or No
If yes, please briefly describe:

Is there anything else you would like me to know that you believe may be relevant to your therapy?

Signature: _____

Printed Name: _____