

Richmond St. Counseling Center
333 Richmond St.
El Segundo, CA 90245

Welcome. I look forward to working with you. This form requests information about you and/or your family that will help me plan your care. If you have any questions, please feel free to discuss them with us.

310.925.0607 Rebecca Kahane, LMFT
310.415.2526 Caryl Bloom, LMFT, Ph.D.

Patient Name _____ Today's Date _____
Address _____ Birthdate _____
City,State,Zip _____ Age _____

Phone # (____) _____ (____) _____ (____) _____

Home OK to leave messages? Y N **Work** OK to leave messages? Y N **Cell** OK to leave messages? Y N

Consent to be added to our email list for occasional Newsletters or Announcements: **Yes** _____ **No** _____

SSN _____ Occupation _____ E-mail _____

Emergency Contact _____
Name Relationship to patient phone number

Referred by _____

Name & phone of primary care physician _____

Name & phone of psychiatrist (if any) _____

Areas of Concern:

Please describe your reason(s) for seeking treatment at this time (include date the problem started): _____

Was there an event that made these issues or problems surface? ___Y ___N If yes, please describe: _____

Do you have any specific goals for treatment? What result(s) do you expect from treatment? _____

What do you consider to be your strengths? _____

Other Information:

Please describe your spiritual/religious orientation _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? ___Y ___N Please describe _____

Has anyone in your family had a serious medical illness? If so, please explain what/when: _____

Has anyone in your family had a psychiatric (nervous or mental) illness? ___Yes ___No If yes, please explain what/when: _____

Any medication? ___Y ___N What? _____ Hospitalization? ___Y ___N When? _____

Please feel free to include any other information that you believe is relevant to your mental health treatment _____

Please indicate & rate the severity (1-4) of the following issues or problems you would like to work on in treatment:

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
___ Anger/Temper	___ Eating Disorder	___ Motivation	___ Headaches
___ Depression	___ Body Image	___ Controlling stress	___ Loss of loved one
___ Problems at school/work	___ Anxiety/Panic	___ Lack of friends	___ Loneliness
___ Problems Coping	___ Domestic Violence	___ Financial Problems	___ Legal matters
___ Relationship Issues	___ Concentration	___ Sleep Problems	___ Fears
___ Shopping Addiction	___ Chronic Illness	___ Energy	___ Divorce/Separation
___ Gambling Addiction	___ Sexuality/Sexual issues	___ Family conflict	___ Behavioral problems
___ Drug/alcohol Addiction	___ Obsessive/Compulsive Behavior	___ ADD/ADHD	___ Low Self Esteem
___ Sex/Porn Addiction	___ Childhood Trauma	___ Adult Trauma	___ Parenting Issues
Any other issues not listed _____			

MEDICAL

When were you last examined by a physician? _____ Outcome? _____

Medications

Type	Dosage	Start Date	Prescribing M.D.	Phone No.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Side Effects _____

Alternative treatments _____

Allergies

Type _____ Severity _____ Treatment _____

Type _____ Severity _____ Treatment _____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc.

IMMEDIATE FAMILY

LIST MEMBERS OF YOUR FAMILY OR OTHERS WITH WHOM YOU LIVE:

Name(s)	Age	Relationship	Occupation

<p>Relationship Status</p> <p>___ single, never married</p> <p>___ engaged ___ mos.</p> <p>___ married ___ yrs.</p> <p>___ divorced ___ yrs.</p> <p>___ separated ___ yrs.</p> <p>___ divorce in process ___ mos.</p> <p>___ live-in for ___ yrs.</p> <p>___ prior marriages (self)</p> <p>___ prior marriages (partner)</p>	<p>Intimate Relationship</p> <p>___ never been in serious relationship</p> <p>___ not currently in relationship</p> <p>___ currently in serious relationship</p> <p>Relationship satisfaction</p> <p>___ very satisfied w/relationship</p> <p>___ satisfied with relationship</p> <p>___ somewhat satisfied w/relationship</p> <p>___ dissatisfied w/relationship</p> <p>___ very dissatisfied w/relationship</p>	<p>List minor children NOT living in same household</p> <table border="0"> <thead> <tr> <th>Name</th> <th>Age</th> <th>Sex</th> <th>Relationship</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> <p>Frequency of visitation of above: _____</p>	Name	Age	Sex	Relationship																
Name	Age	Sex	Relationship																			

Describe any part or current significant issues in **intimate** relationships: _____

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all	Family alcohol/ Drug Abuse History:	
Mother	_____	_____	_____	___ Father	___ Stepparent/Live-In
Father	_____	_____	_____	___ Mother	___ Uncle(s)/Aunt(s)
Stepmother	_____	_____	_____	___ Grandparent	___ Spouse/Partner
Stepfather	_____	_____	_____	___ Sibling(s)	___ Children
Brother(s)	_____	_____	_____	___ Other	_____
Sister(s)	_____	_____	_____		

Parents' current marital status:

___ married to each other

___ separated for ___ years

___ divorced for ___ years

___ mother remarried ___ times

___ father remarried ___ times

___ mother involved with someone

___ father involved with someone

___ mother deceased for ___ years

___ age of patient at mother's death ___

___ father deceased for ___ years

___ age of patient at father's death ___

SUBSTANCE USE HISTORY (check all that apply for patient):

Self-Perception of substance use: Amount	Substances used:	First use age	Last use age	Current?	Frequency
___ None	___ alcohol				
___ Occasional/social	___ amphetamines/speed				
___ Problem use	___ barbiturates/downers				
___ Dependent	___ cocaine/crack				
___ Don't want to stop	___ hallucinogens (LSD,etc)				
___ Addicted/Cannot stop	___ inhalants (glue,etc)				
___ Motivated to stop	___ marijuana or hashish				
	___ PCP/Ecstasy				
Previous treatment:	___ prescription drugs				
___ 12-Step	___ nicotine/cigarettes				
___ Out Patient	___ caffeine				
___ In Patient	___ other _____				

Physical/mental consequences of substance use (check all that apply):

___ outpatient (age(s) _____)	___ hangovers	___ binges	___ blackouts	___ job loss
___ inpatient (age(s) _____)	___ seizures	___ overdose	___ arrests/DUI	___ assaults
___ 12-step program (age(s) _____)	___ withdrawal symptoms		___ sleep disturbances	
___ stopped on own (age(s) _____)	___ medical conditions		___ tolerance changes	
___ other (age(s) _____)	___ relationship conflicts		___ suicidal impulse	
Describe: _____	___ loss of control of amt. used			
___ other _____				

The following information is provided to you so you have a better understanding of how your care will be coordinated. Please read each item carefully and sign in the appropriate spaces.

TREATMENT PHILOSOPHY

During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help you achieve those goals. You are expected to be compliant with the agreed upon treatment plan between sessions and keep your appointments. Research has shown that, often times, brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments.

CONSENT FOR TREATMENT:

I, _____, authorize and request that Rebecca Kahane, LMFT, Lic.#MFC37382 or Caryl Bloom, LMFT, Ph.D., Lic#MFC24817 to carry out psychological examinations, diagnostic procedures, and/or treatment which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement.

I also acknowledge that I have been provided therapist’s Disclosure Statement, have had an opportunity to read same, and hereby agree to the terms stated therein, all of which are expressly incorporated into this Consent for Treatment.

I have read and fully under this Consent for Treatment.

Patient (or Parent/Guardian) Name – *Printed*

Date

Patient (or Parent/Guardian) Name – *Signature*

Date