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

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

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.

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**

Relationship Status

___single, never married
___engaged ____ mos.
___married _____ yrs.
___divorced ____ yrs.
___separated ___ yrs.
___divorce in process ___ mos.
___live-in for ____ yrs.
___prior marriages (self)
___prior marriages (partner)

Intimate Relationship

___never been in serious relationship
___not currently in relationship
___currently in serious relationship

Relationship satisfaction

___very satisfied w/relationship
___satisfied with relationship
___somewhat satisfied w/relationship
___dissatisfied w/relationship
___very dissatisfied w/relationship

List minor children NOT living in same household

Name Age Sex Relationship

_____
_____
_____
_____

Frequency of visitation of above:_____
_____
_____

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

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	_____	_____	_____
Father	_____	_____	_____
Stepmother	_____	_____	_____
Stepfather	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____

Family alcohol/ Drug Abuse History:

___ Father ___Stepparent/Live-In
___ Mother ___Uncle(s)/Aunt(s)
___ Grandparent ___Spouse/Partner
___ Sibling(s) ___Children
___ Other_____
_____

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:

____ **None**
____ Occasional/social
____ Problem use
____ Dependent
____ Don't want to stop
____ Addicted/Cannot stop
____ Motivated to stop

Previous treatment:

____ 12-Step
____ Out Patient
____ In Patient

Amount	**Substances used:**	**First use age**	**Last use age**	**Current?**	**Frequency**
	___alcohol	_____	_____	_____	_____	_____
	___amphetamines/speed	_____	_____	_____	_____	_____
	___barbiturates/downers	_____	_____	_____	_____	_____
	___cocaine/crack	_____	_____	_____	_____	_____
	___hallucinogens (LSD,etc)	_____	_____	_____	_____	_____
	___inhalants (glue,etc)	_____	_____	_____	_____	_____
	___marijuana or hashish	_____	_____	_____	_____	_____
	___PCP/Ecstasy	_____	_____	_____	_____	_____
	___prescription drugs	_____	_____	_____	_____	_____
	___nicotine/cigarettes	_____	_____	_____	_____	_____
	___caffeine	_____	_____	_____	_____	_____
	___other _____	_____	_____	_____	_____	_____

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

____ outpatient (age(s)_____)
____ inpatient (age(s)_____)
____12-step program (age(s)_____)
____stopped on own (age(s)_____)
____other (age(s)_____
Describe:_____
___other _____

___hangovers ___binges ___blackouts ___job loss
___seizures ___overdose ___arrests/DUI ___assaults
___withdrawal symptoms ___sleep disturbances
___medical conditions ___tolerance changes
___relationship conflicts ___suicidal impulse
___loss of control of amt. used

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