

Lisa Brookes Kift, MA.
Marriage & Family Therapist
MFC #45087
711 D. Street, Suite G, San Rafael, CA. 94901
and
1330 Lincoln Blvd., Suite 209, San Rafael, CA. 94901

CONFIDENTIAL CLIENT INFORMATION

Client Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____

Street Address _____ City _____

State _____ Zip Code _____ E-mail Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

May I call you:

at home?	Y	N
on your cell?	Y	N
at your work?	Y	N

Employer _____ Occupation _____

Marital Status _____ Children _____

In Case of Emergency

Notify _____ Relationship _____

Primary Care Physician _____ Phone Number _____

Presenting Problems:

Please describe your reasons for seeking therapy:

Family History:

Describe any significant emotional, medical or chemical dependency conditions of your parents/family:

Psychiatric History:

Have you ever received psychiatric or psychological treatment before? Y N

If you answered "yes" to the above question, please answer the following:

What type of care did you receive?

 Inpatient (hospital)

 Outpatient

 Both

Were you prescribed medications at that time? Y N

If "yes," what was prescribed?

Substance Use History:

Have you ever abused drugs or alcohol? Y N

If "yes," please specify:

Substances Amount Frequency When?

Have you ever received substance abuse treatment of any kind before? Y N

Habits:

Amount Currently Using

Most Ever Used

Coffee (cups/day) _____ _____

Cigarettes (packs/day) _____ _____

Alcohol (drinks/day) _____ _____

Please rate from 0 – 10 how your problems are affecting you in the following areas:

Relationship _____ Family _____ Job/School _____

Friendships _____ Hobbies _____ Finances _____ Physical Health _____

Anxiety level _____ Mood _____ Eating Habits _____

If your eating habits are affected, describe how:

Sexual Functioning _____ Concentration _____

Ability to Control Temper _____ Sleeping Habits _____

If your sleeping habits are affected, describe how:
