

Patt Saso, M.S

Licensed Marriage and Family Therapist, MFC31091
 1313 N. Milpitas Blvd., Suite 141 Milpitas, CA 95035
408-262-6837

Date _____

Name	DOB	Age
Address	City	Zip

List the numbers where it is okay to contact you and/or leave message:

Home phone: _(____)_____ Cell _(____)_____

Work _(____)_____

Occupation_____ How long:_____

How long on present job:_____ Employed by:_____

Birthplace:_____ How long have you lived in this area:_____

Do you practice a religion? Y____ N____ Religion:_____

Last school grade completed:_____ Military Service: _____

I am currently: Married____ How Long?____ Separated____ Divorced____ Widow____ Single____

*If married more than once, list dates of marriages and indicate whether each marriage was terminated by:
 divorce, death or annulment.*

First: 19____ to 19____ Terminated by:_____ Children birthed:_____

Second: 19____ to 19____ Terminated by:_____ Children birthed:_____

Third: 19____ to 19____ Terminated by:_____ Children birthed:_____

Referred by: Self____ Doctor____ Other_____

Types of Help Desired

____ Individual help ____ Couple's counseling ____ Family counseling ____ Don't know

____ Consultation about someone else -- Who?_____

____ Understand my problems so I can make changes

____ Other: _____

1. Major reasons for seeking help

2. Since when have these things bothered you?

3. What do you think may have caused you to feel this way?

4. What have you tried so far?

5. Please list history of previous therapy.

Year	Therapist	Location	Length of treatment	Type of treatment	Results
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6. Check items below that apply to your present condition:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Use alcohol |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Use drugs |
| <input type="checkbox"/> Stomach troubles | <input type="checkbox"/> Depressed | <input type="checkbox"/> Unable to have a good time |
| <input type="checkbox"/> Bowel trouble | <input type="checkbox"/> Panicky feelings | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Feel tense | <input type="checkbox"/> Tremors or tics | <input type="checkbox"/> Can't make friends |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Always worried | <input type="checkbox"/> Can't keep friends |
| <input type="checkbox"/> Unusual thoughts | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Feel apart from people |
| <input type="checkbox"/> Strange experiences | <input type="checkbox"/> Feel worthless | <input type="checkbox"/> Fear things I shouldn't |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Conflict within family |
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Fear I will lose self-control |
| <input type="checkbox"/> Can't go to sleep | <input type="checkbox"/> Ready to explode | <input type="checkbox"/> Other |
| <input type="checkbox"/> Can't stay asleep | <input type="checkbox"/> Unable to work well | |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Can't get interested | |

7. What prescription or over-the-counter medication(s) have you used during this last year?

Medication	Amount	How Often
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8. Have you ever attempted suicide? Yes____ No____

If so, when?_____ Describe the circumstances that led to that attempt.

9. Are you currently having suicidal thoughts? Yes____ No____

If so, please describe:

10. What serious medical problems, surgery, or accidents have happened to you?

11. Are you having any legal problems (lawsuits, child custody, driving under the influence, etc.)? Describe:

Family Data Sheet

Name	City & State of Residency	Age	If Deceased, Age & Year of Death	Marital Status	Occupation	How do you (or did you) get along?
Spouse						
Children (Order of Birth)						
Others Living in Household Now						
Father						
Mother						
Step Parents						
Sisters and Brothers (Order of Birth)						

Which relatives have (or had) emotional difficulties or mental illness -- including depression, alcoholism, abuse issues, etc.?

Relative	Difficulty - Please Describe