MURRAY S KAUFMAN, MA.LMFT,NBCDCH

Marriage and Family Therapy
Clinical Hypnotherapy

Appointment Date:_____

Client Identification

1. Name:_____ 2. Address:_____

3. City: _____ 4. State: _____ 5. Zip:_____

6. Home Phone: _____7. Work Phone: _____8. Cell Phone_____

9. Email: _____10. Fax: _____

11.Date of Birth: _____12. Age_____ 13. Sex_____ 14. Religion_____

15. Ethnicity_____ 16.Marital Status:_____ 17. (#)Children_____

18. Occupation: _____If student, part-time /full-time: _____

19. Employer: _____ 20. Address:_____

21. How did you hear about this practice?

A. Referral Source Name _____Address_____

Phone_____ B. Specify Internet Site _____

22. ***Main Purpose For This Consultation:*** Please give a brief summary of the main problems, and please include whether you have any particular concerns/fears with regard to treatment:

_____

_____

_____

_____

(Please continue to next page)

23. ***Why Are You Seeking An Evaluation At This Time?*** What are your goals for

Counseling/Therapy?

_____

_____

_____

24. Any prior psychiatric, counseling/therapy history or psychological testing? Y or N (If yes please explain)

_____

_____

_____

25. Were these treatments helpful? Please describe: _____

_____

26. Have you ever attempted suicide, or physically hurt anyone intentionally? Y or N If yes, please explain the circumstances and the date(s) of the attempt.

27. Are you currently having any suicidal thoughts or intention to physically hurt someone else?

Y or N (If yes, please describe:)

_____

28. Have you experienced emotional, physical, or sexual abuse? Y or N (If yes, please circle)

29. Have had other traumatic experiences in your life? Y or N

If yes, please briefly describe: _____

(Please continue to next page)

Medical History

1. Current Medical Problems/Disabilities/Medications:_____

_____

2. Current supplements/vitamins/herbs:_____

3. Past medical problems/Medications: _____

4. Other doctors/clinics seen regularly:_____

5. Have you ever injured your head or had a concussion? Y or N If yes, please explain_____

6. Any seizures or seizure-like activity?_____

7. Prior abnormal lab tests? X-rays, EEG, MRI, etc._____

_____

8. Any allergies? Y or N (If yes, please list) _____

_____

9. Prior medical-related hospitalizations? (Place, Cause, Date, Outcome)

_____

_____

10. Have you ever been hospitalized for an emotional disorder ?
Y or N If yes, please describe (place, date, diagnosis) _____

_____

11. Were any members in your family of origin ever diagnosed with an emotional disorder? ____, Y or N (if so, what, and your age at the time) _____

_____***Pg.3 (Please continue to final page)***

12. ***Current Life Stresses*** (include anything that is currently stressful for you, i.e relationships, job, school, finances, children) _____

_____

13. Do you use any recreational drugs? Y/N If yes, please list_____

14. On a scale of 1-10; (1 being the least, and 10 being the most, what do you feel is your current level of stress: _____.

15. What result would you like to see from your therapy? _____

_____.

16. In case of emergency, whom may we contact?

Name: _____ Relationship:_____

Address: _____ City:_____State:_____Zip:_____

Phone: _____.