

April Wright, M.A., LMFT
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Initial Interview Form

Name: _____ **Gender:** _____

Home Address: _____

Phone: _____ **Message OK:** Yes ___ No

Alternate Phone: _____ **Message OK:** Yes ___ No

Email Address: _____

Age: _____ **Date of Birth:** ___ / ___ / ___ **Birth Place:** _____

Relationship Status: _____

Sexual Orientation: _____

Education level: _____

Occupation: _____

Emergency Contact: _____

Relationship to You: _____

Emergency Contact Phone: _____ **Alternate Phone:** _____

Please list names and ages of siblings, if any:

Please describe briefly what brings you into counseling: _____

Symptoms/Chief Complaints:

	Good	Fair	Poor	Yes	No	Yes	No
Sleep:	()	()	()	Restless:	() ()	Nightmares:	() ()

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Appetite: **Weight loss:** **Weight gain:**
Energy level: **Low energy:** **Hyper:**
Attention level: **Crying Spells:** **Sadness:**
Depression: **Anxiety**

Yes No

Suicidal thoughts:

Homicidal thoughts:

Have you ever experienced these thoughts previously? [] Yes [] No

If so, when and how did you cope?

Have you ever physically harmed anyone? [] Yes [] No

If yes, please explain:

Have you ever been arrested for a crime? [] Yes [] No

If yes, please explain:

Has anyone in your immediate and extended family been diagnosed with a psychological or emotional problem? [] Yes [] No

If yes, please specify:

Has anyone in your immediate and extended family had a substance abuse problem?

[] Yes [] No

If yes, who, what substance(s), and duration?

Have you ever been in psychotherapy/counseling before? [] Yes [] No

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If yes, specify dates and type:

What did you like most about therapy?

What did you like the least?

Have you ever been hospitalized for psychological/emotional difficulties, eating disorder(s), alcohol/drugs, surgery or childbirth(s)? [] Yes [] No

If yes, specify dates and reason:

Has any physician ever prescribed medication for psychological problems/emotional difficulties or eating disorder(s)? [] Yes [] No

If yes, specify physician's name, dates, duration of use, and type of medication:

Are you currently using any prescribed or non-prescribed medication?

[] Yes [] No

If yes, name of medication, dosage and reason prescribed:

What are the 3 main areas of stress/ concern in your life?

Please list 4 goals for therapy