Kathy Buratti, M.S., MFT
Licenced Marriage & Family Therapist
15300 Ventura Blvd., Ste. 324
Sherman Oaks, CA 91403
818-900-4535

CLIENT INTAKE QUESTIONNAIRE

GENERAL INFORMATION:

Please fill out this form as completely as possible and bring them with you to our first session. All information is confidential as outlined in my *Informed Consent/Office Policy* form. If you do not wish to answer any question, please write, "do not want to answer."

Date _____ Referral Source _____

Your Name _____ Gender: ☐ Male ☐ Female ☐ Transgender

Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

AGE _____ Date of Birth _____ Place of Birth _____

Emergency Contact Information: Name _____

Relationship To You _____ Phone Number _____

How May Client Be Contacted By Therapist _____
(*please note: email correspondence is not considered to be a confidential medium*):

Client Ethnic Origin: ☐ African American (or black, non-Hispanic) ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Hispanic ☐ White, (non-Hispanic) ☐ Other _____

Languages Spoken at Home: ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ English ☐ Farsi ☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Other _____

Highest Grade/Degree _____ Type Of Degree _____

Occupation _____

Employer _____
Name Address Phone

Current Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced

Describe the nature of your relationship: (i.e. friendly, loving, distant, physically/emotionally abusive, hostile)

_____

_____

_____

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Present Spouse/Partner: Name _____ Age_____

Education _____ Occupation _____

Children: Names and ages of children/step/grandchildren _____

_____

Your Family of Origin Background:

Mother's Name _____ Living? ☐ Yes ☐ No Your age at time of Mother's death (if applicable)_____

Briefly describe your relationship with your Mother _____

_____

Father's Name _____ Living? ☐ Yes ☐ No Your age at time of Father's death (if applicable)_____

Briefly describe your relationship with your Father _____

_____

Siblings: Names/age, if deceased, age and cause of death and brief statement about your relationship _____

_____

_____

Problems/Challenges: *Please mark any of the following problems that you are currently experiencing:*

☐ Depression
☐ Suicidal thoughts
☐ Suicidal actions
☐ Anxiety/fear/worry
☐ Anger/temper issues
☐ Alcohol/other drug abuse (self)
☐ Job/School problems
☐ Financial concerns
☐ Legal problems
☐ Death of a loved one
☐ Major losses/changes in life
☐ Other (*please specify*) _____

☐ Parent-child conflict (self)
☐ Parent-child conflict (spouse/partner)
☐ Marital/relationship problems
☐ Sibling problems
☐ Family violence (actual or threatened)
☐ Communication problems
☐ Sexual problems
☐ Sexual Abuse (current or past)
☐ Physical abuse (current or past)
☐ Gambling issues
☐ Eating/food/body image issues

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How well are you coping? *Please mark any of the following problems that you are currently experiencing:*

- ☐ Change in appetite
  - ☐ More ☐ Less
- ☐ Gaining weight How Much _____Lbs
- ☐ Losing weight How Much _____Lbs
- ☐ Decreased energy/fatigue

Sleep: Average# hours sleep: _____

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Trouble waking up
- ☐ Sleeping too much
- ☐ Nightmares

- ☐ Sexual functioning
- ☐ Moodiness/crying more than usual
- ☐ Hyper/ too much energy
- ☐ Inattentive/Distractible
- ☐ Spending Sprees
- ☐ Phobia
- ☐ Trouble breathing
- ☐ Mood Changes
- ☐ Anger outbursts
- ☐ Disturbing thoughts I can't stop
- ☐ Other (please specify): _____

- ☐ People are picking on me
- ☐ Withdrawing from others
- ☐ Binge; purge
- ☐ Nauseated
- ☐ Diarrhea
- ☐ Constipation
- ☐ Loss of interest in activities usually found pleasurable
- ☐ Feeling guilty, worthless
- ☐ Decreased attention span
- ☐ Problems remembering things
- ☐ Rapid heartbeat
- ☐ Sweating
- ☐ Flashbacks of traumatic events
- ☐ Racing thoughts
- ☐ Worry/fear
- ☐ Panic attacks & frequency
- ☐ People are out to get me
- ☐ Repeated actions I can't stop (washing hands, checking locks, etc)

Medical History: *Please mark any of the following problems that you are currently experiencing or have experienced in the past.*

- ☐ Asthma
- ☐ Epilepsy
- ☐ Cancer
- ☐ Previous Head Injury
- ☐ Diabetes
- ☐ Seizures
- ☐ Heart Condition
- ☐ Thyroid
- ☐ Ulcers
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Gynecological Problems
- ☐ Migraines
- ☐ Stroke
- ☐ Headaches
- ☐ Drug Allergies If yes, list drugs _____ _____
- ☐ Other (Specify)_____

If you answered "yes" to any of the above, please briefly explain:

_____

_____

Current Medications: (prescriptions, over-the-counter and vitamin/herbal supplements). What is amount, frequency, date last used?

_____ _____

_____ _____

Prescribed by whom? _____

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Previous Hospitalizations/Surgeries: *(please list date and reasons)*

Previous suicide attempt(s) or violent behavior to self: *(describe age(s), reasons, methods….) If none, write "NONE"*

Are you currently having any suicidal thoughts? *Please describe*

Have you ever been hospitalized for mental or emotional problems? ☐ Yes ☐ No *If "yes", When, Why and for how long?*

Have you ever taken medications for a mental or emotional condition? ☐ Yes ☐ No *If "yes", What, When and for how long?*

Family History *(Please list any major family health problems, drug or alcohol use)*

Previous Counseling Experiences:
Have you ever been in counseling/therapy before? ☐ Yes ☐ No *If "yes," please list the dates and reasons for counseling*

Was treatment helpful?

How/why did treatment end?

What did you like most about counseling/therapy?

What did you like least about counseling/therapy?

Has any member of your Family been treated for the following?

Schizophrenia ☐Yes ☐No *If "Yes," who?*
Bipolar Disorder ☐Yes ☐No *If "Yes," who?*
Major Depression ☐Yes ☐No *If "Yes," who?*
Substance-Abuse ☐Yes ☐No *If "Yes," who and what substance?*

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Have you ever been treated for the following?

Major Depression	☐Yes	☐No	
Bipolar Disorder	☐Yes	☐No	
Schizophrenia	☐Yes	☐No	
Substance Abuse	☐Yes	☐No	*If "Yes," what substance?*_____
Addiction (sex, gambling, eating, etc.)	☐Yes	☐No	*If "Yes," specify addiction*_____

Your Lifestyle:

Do you use caffeine products?	☐Yes	☐No	*How much per day?* _____
Do you smoke?	☐Yes	☐No	*For how long?* _____ *How many per day?* _____
Do you drink alcohol?	☐Yes	☐No	*On average, how much per week?* _____
Do you use other drugs?	☐Yes	☐No	*If "yes," which ones:* _____ *How much?* _____
Have you ever been treated for substance abuse?	☐Yes	☐No	
Are there any guns or weapons in your home?	☐Yes	☐No	
Have you ever had legal charges brought against you?	☐Yes	☐No	*If "yes," please specify what kind of charges and when they were issued:*

_____

_____

Relationship Experiences: *Please mark any that currently apply to you:*

- ☐ I don't have enough friends
- ☐ I talk to my friends about my problems
- ☐ I consider myself to be shy
- ☐ I make friends easily
- ☐ Other people pick on me
- ☐ I have enough friends
- ☐ I don't talk to my friends about my problems
- ☐ I find it very difficult to open up to others
- ☐ I find it hard to keep friends
- ☐ Few people seem to understand me

Your Sources of Stress: *Please list the 3 most common sources of stress in your life at the present time. Include significant losses and changes in your life.*

1) _____

2) _____

3) _____

How do you cope with stress? *Please list the 3 coping strategies you use most often (sleep, yoga, exercise, etc.):*

1) _____

2) _____

3) _____

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Current Functioning:
Using the following scale, please circle the number that most accurately indicates your current level of functioning.
"0" is lowest (not coping at all), while "10" means that you are coping with things better than you ever have.

Areas Of Concern:
What issues/concerns cause you to seek treatment at this time? *Please describe*:

Your Goals: Do you have any specific goals with regard to your treatment?

Do you have any particular concerns/fears with regard to treatment?

Your Consent To Participate In Therapy:

Client Name _____

Client Signature _____ Date _____

Parent/Guardian Signature (if under age 18) _____ Date _____

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CANCELLATION POLICY

A full session fee is charged for missed appointments or cancellations with less than 24-hour notice.

_____
Client Signature (Client's parent or guardian if under 18)

_____
Client Name

_____
Today's Date