Jan Stolpe, M.A., LMFT
Licensed Marriage & Family Therapist, MFT#: 90052
10801 National Blvd., Suite 571, Los Angeles, CA 90064

## Confidential Client Information

**Name:** _____

**Reason for seeking Therapy:** _____

_____

**Please circle the symptoms you are currently experiencing:**

| | Mild | Moderate | Severe | How long ... |
|---|---|---|---|---|
| Depressed | 1 | 2 | 3 | _____ |
| Mood Hopelessness | 1 | 2 | 3 | _____ |
| Suicidal Thoughts | 1 | 2 | 3 | _____ |
| Appetite Changes | 1 | 2 | 3 | _____ |
| Weight change | 1 | 2 | 3 | _____ |
| Poor Concentration | 1 | 2 | 3 | _____ |
| Obsessive Thoughts | 1 | 2 | 3 | _____ |
| Strange Thoughts | 1 | 2 | 3 | _____ |
| Tension/Anxiety | 1 | 2 | 3 | _____ |
| Panic Attacks | 1 | 2 | 3 | _____ |
| Memory Problems | 1 | 2 | 3 | _____ |
| Compulsive Behavior | 1 | 2 | 3 | _____ |
| Hostility or Anger | 1 | 2 | 3 | _____ |
| Violent Acts | 1 | 2 | 3 | _____ |
| Social Isolation | 1 | 2 | 3 | _____ |
| Sexual Problems | 1 | 2 | 3 | _____ |

**Please Circle:**

**Alcohol Use:** None 1-4 times/month 3-4 times/week daily

**Amount:** None 1-2 drinks/sitting 2-4 drinks/sitting 5 or more drinks/sitting

**Intoxication:** None 1-4 times/month 3-4 times/week daily

**Circle all used:** Marijuana Opiates Sedatives Stimulants Cocaine Hallucinogens

**Frequency :** _____

**Have you ever been arrested?** Yes No

**Any medical problems (incl. allergies)?**

_____

_____

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**Current Medications (incl. non-prescription):**

_____

_____

**Current or past thoughts of suicide or suicide attempts (date and brief circumstance):**

_____

_____

**Current or past thoughts of violence towards another person (date and brief circumstance):**

_____

_____

**Person paying for my therapy:**

_____

## Confidential Client Information

Name: _____ Birth date: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer/School: _____ Position: _____

In case of emergency notify: _____ Phone: _____

Physician:_____ Phone: _____

Psychiatrist: _____ Phone: _____

Other: _____ Phone: _____

_____ _____
(Signature) (Date)

_____ _____
(Signature of legal Guardian if applicable) (Date)