MONIKA SUMMERFIELD LMFT # 41527
16052 Beach Blvd. Suite 212, Huntington Beach CA 92647

NEW CLIENT INFORMATION

NAME: _____ Date: _____

Age: _____ Date of Birth: _____ Email: _____

Address: _____

Phone: cell: _____ home / work: _____

Occupation: _____ Primary Care Physician: _____

EmergencyContact: _____ Tel: _____ Relationship: _____

Referred by: _____ Online: _____ Other: _____

SYMPTOMS

PLEASE mark all symptoms you have experience by marking the level the best describes their severity. Circle one level for each applicable symptom and indicate how long the symptoms have been present.

SYMPTOM	SEVERITY			DURATION, SINCE WHEN
Depression……	Mild	Moderate	Severe	_____
Fatigue/Lethargie…	Mild	Moderate	Severe	_____
Hopelessness……	Mild	Moderate	Severe	_____
Helplessness ……	Mild	Moderate	Severe	_____
Body Complains ……	Mild	Moderate	Severe	_____
Suicidal Ideas……	Mild	Moderate	Severe	_____
Weight Gain……	Mild	Moderate	Severe	_____
Weight Loss……	Mild	Moderate	Severe	_____
Lack of Concentration	Mild	Moderate	Severe	_____
Sleep Disorder…..….	Mild	Moderate	Severe	_____
Nightmares……..…	Mild	Moderate	Severe	_____
Anxiety / Worry……	Mild	Moderate	Severe	_____
Panic/ Phobias……	Mild	Moderate	Severe	_____
Obsession/Compulsions	Mild	Moderate	Severe	_____
Poor Impulse (Temper)	Mild	Moderate	Severe	_____
Irritability/lack of caring…	Mild	Moderate	Severe	_____
Unusual Energy……	Mild	Moderate	Severe	_____
Forgetfulness/Memory…	Mild	Moderate	Severe	_____
Racing/neg.Thoughts.…	Mild	Moderate	Severe	_____
Disorganized Thinking…	Mild	Moderate	Severe	_____
Binging/Purging……..	Mild	Moderate	Severe	_____
Alcohol/Drugs over use..	Mild	Moderate	Severe	_____

CONTRIBUTING FACTORS:

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Family / Marriage	Mild	Moderate	Severe	_____
Job /School performance	Mild	Moderate	Severe	_____
Friendships/Relationships	Mild	Moderate	Severe	_____
Hobbies, Activities	Mild	Moderate	Severe	_____
Trauma, Stress	Mild	Moderate	Severe	_____
Physical Health	Mild	Moderate	Severe	_____
Sexual Functioning	Mild	Moderate	Severe	_____
Spirituality	Mild	Moderate	Severe	_____

Please circle how these aspects of your life affect, cause, or relate to any of your symptoms.

PSYCHIATRIC HISTORY:

Have you received psychiatric or psychological treatment of any kind before, if yes please describe:

What type of care? Inpatient/Hospital/Rehab: _____

Outpatient: Psychiatrist: _____ Are you in treatment now? YES ___ NO___

Medications/Dosage: _____

_____

Past Medication:_____

_____

Did they help? YES ___ NO____Where there side effects? YES ___ NO____ If yes, please list:

_____

Name of Psychologist: Past or now? Other Services: Self-Help Addiction (AA) etc., Community Resources, Agencies, Schools (please indicate)

_____

_____

	Amount	Frequency	When (first use, last)
Alcohol	_____	_____	_____
Cigarettes	_____	_____	_____
Amphetamines /Cocaine		_____	_____
Marijuana	_____	_____	_____
Heroin	_____	_____	_____
Prescription Medication		_____	_____
Other: _____	_____	_____	_____

SUBSTANCE USE/ABUSE HISTORY:

Please indicate current or past use :

MEDICAL HISTORY:

Please list any medications, supplements you are currently taking, dosage and frequency

_____

_____

Please list illnesses/conditions that you are treated for and that affect your wellbeing:_____

_____

_____

_____

Date of last physical: _____