kiefer rich,lmft

Kiefer Rich, Licensed Marriage and Family Therapist

Please provide the following information and answer the questions below. Please note: information you provide here is ***protected as confidential information****.*

I do not discriminate based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

Name: ____

(Last) (First) (Middle Initial)

What is your preferred name and what pronouns do you prefer (e.g. he/him, she/her)?

____

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________

What is your current gender identity? (check ALL that apply)

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/FTM
- ☐ Transgender Female/Trans Woman/MTF
- ☐ Additional Category (please specify) _________
- ☐ Gender Queer

Relationship Status:

- ☐ Never Married
- ☐ Partnered
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living Together
- ☐ Other

Please list any children/age: ____

Address: ____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: ( ) _______________________ May I leave a message? ☐Yes ☐No

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Mobile Phone: (   ) ______________________ May I leave a message? □Yes □No

E-mail: ____ May I email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact:____
(Name) (Relationship) (Contact Number)

How shall I explain who I am:____

Referred by (if any): ____

PREVIOUS MENTAL HEALTH SERVICES

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

❑ No

❑ Yes, previous therapist/practitioner: ____

Purpose: ____

2. Are you currently taking any prescription medication?

❑ No

❑ Yes, Please list: ____

3. Have you ever been prescribed psychiatric medication?

❑ No

❑ Yes, Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please check)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:____________________

____

2. How would you rate your current sleeping habits? (please check)

Poor Unsatisfactory Satisfactory Good Very good

Please check where appropriate :

□ Sleeping too little □ Sleeping too much □ Poor Quality Sleep

□ Disturbing Dreams □ Other

Please list any other sleep problems you are currently experiencing: ______________________

____

3. How many times per week do you generally exercise? ______________________________________

What types of exercise to you participate in: ____

4. Please list any difficulties you experience with your appetite or eating patterns.

□ None □ Eating less □ Eating more □ Binging □ Restricting □ Purging

5. Are you currently experiencing overwhelming sadness, grief or depression?

❑ No

❑ Yes If yes, for approximately how long? ________________________

6. Are you currently having any suicidal feelings or behaviors?

❑ No

❑ Yes If so, for how long? ________________________

7. Have you had suicidal thoughts recently?

□ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past?

□ Frequently □ Sometimes □ Rarely □ Never

8. Are you currently experiencing anxiety, panic attacks or have any phobias?

❑ No

❑ Yes If yes, when did you begin experiencing this? ___________________________

9. Are you currently experiencing any chronic pain?

❑ No

❑ Yes If yes, please describe? ___________________________

10. Do you drink alcohol more than once a week? □ No □ Yes

11. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

12. Are you currently in a romantic relationship? □ No □Yes

If yes, for how long? ___________________

On a scale of 1-10, how would you rate your relationship? __________

13. What significant life changes or stressful events have you experienced recently:

____

____

____

14. Have you ever experienced :

Extreme Depressed Mood... □Yes □No

Wild Mood Swings.. □Yes □No

Rapid Speech.. □Yes □No

Extreme Anxiety .... □Yes □No

Panic Attacks.. □Yes □No

Phobias... □Yes □No

Sleep Disturbances.. □Yes □No

Hallucinations... □Yes □No

Unexplained losses of time.................................... □Yes □No

Unexplained memory lapses.................................. □Yes □No

Alcohol/Substance Abuse.. □Yes □No

Frequent Body Complaints....................................... □Yes □No

Eating Disorder... □Yes □No

Body Image Problems.. □Yes □No

Repetitive Thoughts (e.g. obsessions) .... □Yes □No

Repetitive Behaviors (e.g. frequent hand-washing, frequent checking) □Yes □No

Homicidal Thoughts.. □Yes □No

Suicide Attempts... □Yes □No

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		List Family Member
Alcohol/Substance Abuse	☐Yes ☐No	____________________
Anxiety	☐Yes ☐No	____________________
Depression	☐Yes ☐No	____________________
Domestic Violence	☐Yes ☐No	____________________
Eating Disorders	☐Yes ☐No	____________________
Obesity	☐Yes ☐No	____________________
Obsessive Compulsive Behavior	☐Yes ☐No	____________________
Schizophrenia	☐Yes ☐No	____________________
Suicide Attempts	☐Yes ☐No	____________________

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

Do you enjoy your work?

Is there anything stressful about your current work? ____________________

____

If unemployed, are you?

Full-time student................ □Yes □No

Part-time student................ □Yes □No

On Disability..................... □Yes □No

Retired.......................... □Yes □No

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:____

____

3. What do you consider to be some of your strengths? ______________________________

____

____

____

4. What do you consider to be some of your weakness? ______________________________

____

____

____

5. What would you like to accomplish out of your time in therapy?____________________

____

____

____

____