Gail L. Braverman, M.A.

Marriage & Family Therapist

License #LMFT 35281

5100 Marlborough Drive

San Diego, California 92116

gailbravermanlmft@gmail.com

619.282.4730

Patient Questionnaire/Intake

General:

Name _____ D.O.B._____ Date_____

Address _____ Home phone _____

Work phone _____ Fax _____

E-mail _____ Referred by _____

Marital status _____ Educational level _____

Occupation _____

Names and ages of children: _____

_____

Emergency contact information _____

Financial Information:

How do you intend to pay for treatment? (Cash, Check, Charge)

_____

Areas of Concern

What issues/concerns causes you to seek treatment? Please describe. _____

_____

_____

_____.

Do you have any specific goals with regard to your treatment? _____

_____

_____.

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

_____

_____.

Psychological History:

Have you ever received mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Name of treating therapist(s), address(es), telephone number(s) _____

_____

*Authorization for release of confidential information may be needed so that former therapist may be contacted if needed.

Have you ever been subjected to one or more psychological tests? _____

If so, by whom and what test/s?

_____

Name of person(s) administered psychological tests, address(es), telephone number(s)

_____

_____

Have you ever attempted suicide? _____ When? _____

_____

Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? Please describe

_____

_____

_____

Please describe your childhood

_____

_____

_____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe:

_____

_____

Have you ever been a victim of a violent crime or trauma? Please describe:

_____

_____

Medical History

Have you ever been diagnosed with a serious illness? Please describe _____

_____

_____

Do you have any medical conditions that may affect your mental health treatment?

_____

Please describe your overall health today. _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

_____

_____

Have you ever been in a 12-step program? Please describe. _____
_____

Do you smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____

On average, how much alcohol do you consume in a week?_____

Do you currently use illegal drugs? Please describe your use _____
_____

Have you ever used illegal drugs? Please describe. _____
_____

Family of Origin History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____
_____
_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____
_____
_____

Names and ages of siblings. _____
_____

Other Information

Please describe your spiritual identity/orientation. _____

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? _____

Please describe. _____
_____

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____.