Jessica Gillespie, LMFT
Licensed Marriage and Family Therapist, MFT 98993
626.708.0449 | hello@jessicagillespiemft.com

Client Information & Intake

Please fill out this biographical background form as completely as possible. It will help us in our work together. You can either email it back to me at jessicagillespiemft@gmail.com as an email attachment, or bring it with you to our first session. Information is confidential as outlined in the Consent form and Notice of Privacy Practices.

Client Name:

____
(Last) (First) (MI)

Parent(s)/guardian(s) (if under 18 years):

____
(Last) (First) (MI)

Birth Date: _______ /_______ /_________ Age: __________ Gender: □ Male □ Female

How do you identify, culturally (ethnicity, race, religion, etc.)?

____
____

Address:

____
(Number and Street)

____
(City) (State) (Zip)

Primary Phone:(______)________________May I leave a general voicemail? □Yes □No
Secondary Phone:(______)______________May I leave a general voicemail? □Yes □No
E-mail: ____May I email you? □ Yes □ No
**Please note: Email correspondence is NOT considered to be a confidential medium of communication.*

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Gender Identity:
□ Female □ Male □ Transgender: __________ □ Genderqueer □ Intersex
□ Other: __________

Sexual Orientation:
□ Heterosexual/Straight □ Homosexual/Gay □ Bisexual □ Questioning

□ Other: _________

Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long____________ On a scale of 1 to 10 (10 being best), how would you rate your relationship? __________

Please list any dependents (children/parents and ages):

____

____

Emergency Contact (Name/Phone):

____

How did you hear about me?

____

General Health and Mental Health Information:
PRESENTING PROBLEM (Why are you seeking counseling services at this time. Be as specific as you can: when did it start, how does it affect you.):

____

____

____

____

Severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

Have you ever received any type of mental health services (psychotherapy, groups, testing/assessment, psychiatric services, etc.)? □ Yes □ No
Names/types of therapists/practitioners:

____

____

Current vitamins/supplements and/or prescribed medications, if any:

____

____

Current or previous prescribed psychiatric medication, if any:

____

____

How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

____

____

Medical Doctor (Name/Phone):

____

How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please describe any difficulties with your appetite or eating patterns:

How many times per week do you generally exercise?

Type:

Are you currently experiencing overwhelming sadness, grief, or depression?
□Yes □No
If yes, for approximately how long?

Are you currently having any thoughts of suicide? □Yes □No
If yes, how often? ________
Have you had any prior suicide attempts? ________
If yes, please list the approximate date(s):

Are you currently experiencing anxiety, panic attacks, or have any phobias?
□Yes □No
If yes, when did you start experiencing this?
If yes, how frequently do you experience this?

Are you currently experiencing any chronic pain? □Yes □No
If yes, please describe:

Do you drink alcohol more than once a week? □Yes □No
If yes, how often/amount:

How often do you engage recreational drug use? (please circle)
Daily Weekly Monthly Infrequently Never

What significant life changes or stressful events have you experienced recently?

Personal and Family Mental Health History:
In the section below, identify if there is a family history – including yourself – of any of the following. If yes, please indicate the family member's relationship to you in the space provided (self, father, grandmother, uncle, etc.).

	Please circle	**List Self or Family Member(s)**
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	

Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	
Violent/Assaultive Behavior	Yes / No	
Other (Describe)		

History:

Briefly describe or list significant events from your CHILDHOOD (e.g., relationship with parents, siblings, divorce, school/behavioral problems, moves, trauma):

____

____

____

Briefly describe or list your SOCIAL SUPPORT (e.g., friendships, spiritual community):

____

____

____

Briefly describe or list your EDUCATION (e.g. highest grade/degree, academic performance/interests):

____

____

____

Are you involved in any current or pending CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

____

____

____

Additional Information:

Do you currently have employment/source of income? □ No □ Yes

Please describe:

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

What do you consider to be some of your strengths?

____

____

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

____

____

____