Jenn Harrington, M.A., LMFT#84768

Marriage, Child, & Family Therapist

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Name: ____ Date: ___________________

Address: ______________________________ City: ________________ State: _____ Zip: _______

Home Phone: _______________ Cell: ___________________ Work: _______________________

Email: ____________________________ Referred by:_________________________________

Please indicate if messages can be left or mail sent:

Home Phone: □ yes □ no Work Phone: □ yes □no Cell Phone: □ yes □ no Home Address: □ yes □ no

In case of emergency, please contact: ________________________ Phone: ____________
Relationship:_________

Date of Birth: __________________ Age: _______ Social Security #: ______-_____-_______

Marital Status (circle): S M W Se D # Years Married: _______ Spouse Name: _____________________

Children (names & ages):

____

Place of Employment: ________________________ Occupation: ___________________________

Briefly describe why you are seeking therapy at this time:

____

____

____

Primary Care Physician: _____________________________ Phone: _________________________

Do I have permission to coordinate care with your Primary Care Physician? □ yes □ no

Date of last physical examination:

____

Treating Psychiatrist: ____________________________ Phone: ______________________________

Current Medications: Dosage Prescribing Physician

________________________________ _____________________________

____

________________________________ _____________________________

____

________________________________ _____________________________

____

________________________________ _____________________________

____

Previous Therapist: ___________________________ Dates of Service: from_________ to __________

Issues addressed in therapy:

____

____

____

Do you currently have any medical conditions that you are being treated for? □ yes □no

Please explain:

____

____

____

If you have ever been hospitalized, please list when and for what reason.

____

____

____

____

Have you ever experienced any trauma in your life? □yes □no If so, please briefly explain:

____

____

____

List 5 things about yourself that you like:

____

____

____

List 5 things about yourself that you would like to change:

____

____

____

What are your major strengths?:

____

____

____

Have any anniversaries of important or stressful events in your life occurred recently or are any due to occur soon?

____

____

____

List any major problems or stressful events that other family members or close friends are currently dealing with:

____

____

What solutions or efforts have you tried to solve the problems that bring you here?

____

____

Do you have any religious affiliation? _________________ If so, what denomination?: ______________

Are you □practicing or □non-practicing in your faith?

Do you want to have your faith integrated into therapeutic treatment? □yes □no

Family History:

Relationship Living? Deceased? Age If living, location

Mother:

____

Father:

____

Brothers:

____

____

____

Sisters:

____

____

____

Is there any family history of mental illness? □yes □no

Are there issues with your family of origin that you believe are influencing the quality of your life today?

If so, please describe:

____

____

____

____

Describe the events or interactions that precipitated your concerns?

Please check those that apply:

__ Depressed mood __Panic attacks __High stress

__Eating disturbance __Anger/temper __Social skills problems

__Physical abuse __Gender issues __Relationship issues

__Hallucinations __Alcohol/drug abuse __Low energy/fatigue

__Low self-esteem __Sleep disturbance __Co-dependency

__Phobia/fears __Sexual abuse __Sexual disturbance

__Chronic pain __Aggressive Behaviors __Obsessive/Compulsive Issues

__Avoidant behaviors __Suicidal thoughts __Grief/Loss

__Other (please specify)____

__Present/past substance use (please specify substance(s) ___________________________________

How often do you use the substance: ___/day ___ week/ ___month/ ___year

Do you drink alcohol? □yes □ no

If so, how much beer, wine or hard liquor do you consume each week on average?

____

Have you ever felt the need to cut down on your drinking? □yes □no

Have you ever felt annoyed by criticism of your drinking? □yes □no

Have you ever felt guilty about your drinking? □yes □no

Have you ever had a DUI (Driving Under the Influence) arrest? □yes □no Date:

____

Do you smoke cigarettes? □yes □no How many packs per day?

____

Do you use recreational drugs? □yes □no If yes, what substances do you use, and how often?

____

Do you have any compulsive behaviors that you would like to address in therapy?

____

____

Other important information you would like to share: