Dr. Seima Diaz, Ed.D, LMFT
Licensed Marriage Family Therapist #MFC89056
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ADULT CLIENT INFORMATION FORM

Name: ____

Address: ____

____

Date of Birth: ____________________ **Age:** ________

Gender: Woman: ___ Man: ___ Transgender: ___ Transman: ___ Transwoman: ___ Gender Nonconforming: ___
Other: ____________________________ Prefer not to answer: ___

Orientation: Straight: ___ Gay: ___ Lesbian: ___ Bisexual: ___ Asexual: ___ Queer: ___ Questioning: ___
Other: ____________________________ Prefer not to answer: ___

Employer & Occupation: ____

Home phone: _____________________ **Cell Phone:** _____________________ **E-mail Address:** ____________________

Can a message be left at any or all of the numbers? Home _________ Cell _________
Please indicate the means by which you prefer to be contacted. Home _________ Cell _________ E-Mail _________

Marital Status: ___Married ___Remarried ___Single Parent ___Widow ___Divorced ___Separated

Do you have children? ___Yes ___No If yes, list names and ages ____

____

Current Employment Status: (Please check all that apply): Working Full-Time: ____________ Working Part-Time: ________
Retired: ____________ On medical leave: ____________ Unemployed and looking for work: ____________ Not employed due to other reasons ____________ Full-Time Student: ____________ Part-Time Student: ____________

Education Information: (Please check the highest level of education/degree you have received): Elementary, Grades 1-8: _____ Some High School (no diploma): _____ High School Diploma/GED: _____Some College (no degree): ______
Technical/Trade School Graduate: _____Associate's Degree: ______ Bachelor's Degree: ______ Master's Degree: _____
Professional Graduate Degree (i.e., MD, JD, etc.):______ Doctoral Degree (i.e., PhD, EdD, etc.):______

Military History: Currently on active duty: ________ Served in Military (please circle length of time served) for: ______ number of weeks, months, or years. Never served in the military: ________________ If you have served in the military were you ever deployed, yes or no? Yes: _____ No: ____.

If yes, please describe your deployment experience and any incidence or issues that arose for you during or after your deployment:

____
____
____

Legal History: Have you been ordered by the court to participate in this therapy, yes or no? Yes: ____ No: ____If yes, you may be required to supply supporting documentation such as a copy of the court order. Are you currently involved in any kind of litigation or legal dispute, yes or no? Yes: _____ No: _____ If yes, please explain (i.e., custody dispute, dissolution proceedings, etc.):

____
____
____

Who referred you? ____ May we contact this person? ______

In case of an emergency, contact:

Name _____________________________ Relationship _________________________ Phone _______________________

What type of services are you currently seeking? Please mark an “X” by the type of services you are seeking.
Individual therapy _________ Marital/Couples therapy _________ Family therapy _________ Group Therapy _________
Other (describe) _________ Unsure _________

Payment Information: Please indicate how you intend to pay for treatment: Cash: ___ Check: ___ Credit Card: ____
Insurance: _____ Third-Party: _______. If a third-party will be paying for your treatment, please provide the following information: Name of the person paying for your therapy: ___________________
Your Relationship to this person: ____
Contact Information for this person: ____

Goals of Treatment:
What compelled you to seek therapy at this time?

____
____
____

Describe your current concerns, issues, or problems that you hope to resolve:

____
____
____

What do you hope to gain from therapy?

____
____
____

Symptoms & Concerns:

Please check any that apply to you and circle those that are the most significant.

____ Adjustments (new job, marriage, divorce, death in family, move to new location, etc.)	____ Health concerns (physical symptoms)	____ Anxiety/worry
	____ Sleeping difficulties	____ Sadness/Depression
____ Learning disability	____ Nightmares	____ Obsessive/Compulsive
____ Personal growth	____ Eating Problem	____ Mood changes
____ Religious/Spiritual concerns	____ Physical disability	____ Aggression/violence
____ Relationship problems	____ Chronic illness	____ Guilt
____ Parent-child relationship problem	____ Terminal illness	____ Anger/irritability
____ Sexual concerns	____ Trauma	____ Addition
____ Abuse or assault victim	____ Career decisions	____ Suicidal thinking

Family or personal history of learning, emotional, or behavioral difficulties? ___Yes ___No If yes, please describe:

____

____

____

Family or personal history of alcohol/drug/substance use? ___Yes ___No If yes, please describe:

____

____

____

Family or personal history of family violence or criminal activity? ___Yes ___No If yes, please describe:

____

____

____

If you have ever seen a mental health professional (psychiatrist, psychologist, or counselor), please list when, who, and why they were seen.

____

____

____

Are you currently taking any medications? If yes, please list and explain. If you are currently taking psychiatric medication, please list the type of medication, the specific medication you have been prescribed, the dosage, and any side effects in the space below. *For example: "Antidepressant (type), Zoloft (specific medication), 50mg once daily (dose), Insomnia (side effect)."*

____

____

____

Primary Care Physician Name, phone number: ____

Spiritual/Cultural History:

Do you identify with a particular religion, culture, or spiritual practice? If so, please describe:

___

___

___

Do any of the above religious, cultural, or spiritual issues contribute to your current concerns, problems, or issues? If so, please describe:

___

___

___

Additional Information:

Please let me know in the space provided, of anything that was not addressed in this intake, and anything that you would like me to know about you, your goals, your relationships, or any recent significant life events:

___

___

___

Signatures: I certify that the information provided above is accurate to the best of my knowledge. If any of the information changes, I will provide updated information to Dr. Seima Diaz, Ed.D, MFT as soon as possible.

____   ________________________

Client Signature   Date