Mental Fitness Lifestyle, Inc.
22231 Mulholland Hwy. , Suite 210
Calabasas, California 91302

OFFICE USE ONLY

Dx Name:

Dx Number:

ADULT CLIENT INFORMATION

Name:_____ Date:_____

Home Address:_____
Street City Zip Code

Home Phone #:_____ E-Mail Address: _____

Cell Phone #:_____ Work Phone #: _____

PLEASE CIRCLE PHONE NUMBER AT WHICH YOU WOULD LIKE CONFIDENTIAL MESSAGES LEFT

Birth Date:_____

Employer:_____ Occupation:_____

Marital Status:_____ If married, spouse's name:_____

Previous Therapy:_____
Therapist's Name Period of Time Therapy Issue(s)

Physician:_____ Phone #:_____

Please describe your living arrangements:

_____ _____
Name Age Relationship Name Age Relationship

_____ _____
Name Age Relationship Name Age Relationship

In case of emergency, please notify:_____

Relation: _____ Phone #:_____

Who referred you to my practice?_____

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person**. No other information will be disclosed.

Signature:_____ Date:_____

INTAKE INFORMATION

Why are you seeking therapy at this time? _____

_____

_____

_____

_____

Check any symptoms you have exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Difficulty with Authority Figures
___ Often in Trouble
___ Argumentative
___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Difficulty Sleeping in Own Bed
___ Very Active
___ Easily Distracted
___ Has Conflicts with Peers
___ Doesn't Follow Directions
___ Other (please describe): _____

List and describe any history of emotional disorder(s) in your biological family:

_____

_____

_____

_____

List and describe any significant life events (e.g. divorce, death in family, etc.):

_____

_____

_____

List and describe any current or historical physical concerns (e.g. ulcers, headaches, etc.):_____

_____

_____

_____

_____

List and describe any drug and/or alcohol use: _____

_____

_____

_____

List any medication(s) and dosage you are currently prescribed: _____

_____

_____

_____

Prescribing Physician: _____ Phone: _____

What are your strengths and hobbies? _____

_____

_____

_____

List your three primary treatment goals:

1. _____
2. _____
3. _____