

# Myra J. Mayesh, MA, MFT

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## CLIENT INFORMATION AND HISTORY

*If there are any questions that you do not feel comfortable addressing in writing, please put an \* by it and we will discuss during your initial session.*

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ May I leave a message? Y N

Work Phone: \_\_\_\_\_ May I leave a message? Y N

Cell Phone: \_\_\_\_\_ May I leave a message? Y N

Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Highest school year completed: \_\_\_\_\_ Military Service Y N

If yes, what branch: \_\_\_\_\_ Dates: \_\_\_\_\_ Combat? Y N

Ethnicity/heritage: \_\_\_\_\_

Religious/spiritual affiliation: \_\_\_\_\_

Gender: Male Female Other (identify) \_\_\_\_\_

Sexual Orientation: Heterosexual Bisexual Gay/Lesbian Questioning

Other (identify):` \_\_\_\_\_

With whom do you live? \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Other (specify): \_\_\_\_\_

Do you have children? Y N If yes, please list their names and ages:

Name	Age	Name	Age

Name of Spouse/Significant Other: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

What is your primary reason/concern for seeking counseling? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the biggest challenges you are facing in your life? \_\_\_\_\_  
\_\_\_\_\_

Please describe your current support system: \_\_\_\_\_  
\_\_\_\_\_

**Treatment and Medical History**

Are you currently receiving, or have you previously received services from a counselor/mental health professional (i.e. psychiatrist, therapist)? Y N

If yes, please list provider name, contact information and dates of treatment:

Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Dates of Treatment \_\_\_\_\_

Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Dates of Treatment \_\_\_\_\_

Have you ever been hospitalized for psychiatric or drug/alcohol treatment? Y N

If yes, please describe the circumstances, including length of hospitalization and dates:

\_\_\_\_\_  
\_\_\_\_\_

Have you ever attempted suicide? Y N If yes, how many times and when? \_\_\_\_\_

Are you having suicidal thoughts now? Y N If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Please list any medications you are currently taking:

Medication	Dosage	Date Started	Prescribing Physician

Please list any herbal supplements or other non-prescribed meds you are currently taking:

Other Supplements	Dosage	Date Started

What is your current use of alcohol and/or drugs? \_\_\_\_\_

Are you currently receiving treatment for a medical condition? If yes, please describe:

Name of Primary Health Care Provider/Physician: \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please describe your state of health and any physical problems you may have at this time:

**Psychosocial History**

Are you aware of any history of mental illness, alcoholism, or drug abuse in your family? Y N

If yes, please describe: \_\_\_\_\_

Any history of physical, emotional, or sexual abuse? Y N

If yes, please describe: \_\_\_\_\_

Have you ever been the victim of a crime? Y N

If yes, please describe: \_\_\_\_\_

Have you ever been the perpetrator of a crime? Y N

If yes, please describe: \_\_\_\_\_

Please add anything else you would like me to know about you at this time:

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THANK YOU