

# Meg Kaufman, MFT

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Name: \_\_\_\_\_  
(Last) (First)

How would you prefer to be addressed? \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Local Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: ( ) \_\_\_\_ - \_\_\_\_ May we leave a msg?  Yes  No

Cell/Other Phone: ( ) \_\_\_\_ - \_\_\_\_ May we leave a msg?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

List Below the people living with you:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by: \_\_\_\_\_

May I thank the person who referred you?  Yes  No

Highest level of education attained \_\_\_\_\_ Degree? \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere?  
 Yes  No

Have you had previous mental health care (psychologist, psychiatrist, marriage counseling etc.)  
 Yes  No If yes, name of therapist \_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)

In case of emergency: Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_ - \_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_ - \_\_\_\_



1. How is your physical health at present?

Poor    Unsatisfactory    Satisfactory    Good    Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

---

---

3. Are you having any problems with your sleep habits?  No     Yes

If yes, check where applicable:

- Sleeping too little     Sleeping too much     Poor quality sleep  
 Disturbing dreams     Other \_\_\_\_\_

4. How many times per week do you exercise? \_\_\_\_\_

Approximately how long each time? \_\_\_\_\_

5. Are you having any difficulty with appetite or eating habits?  No     Yes

If yes, check where applicable:  Eating less     Eating more     Binging     Restricting

6. Do you regularly use alcohol?  No     Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period? \_\_\_\_\_

7. How often do you engage recreational drug use?  Daily     Weekly     Monthly

Rarely     Never

8. Have you had suicidal thoughts recently?

Frequently     Sometimes     Rarely     Never

9. Are you currently in a romantic relationship?  No     Yes

If yes, how long have you been in this relationship? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your current relationship? \_\_\_\_\_

10. In the last year, have you experienced any significant life changes or stressors:

---

**Have you ever experienced:**

Yes / No

Extreme depressed mood	
Wild Mood Swings	
Extreme Anxiety	
Panic Attacks	
Phobias	
Sleep Disturbances	
Unexplained losses of time	
Unexplained memory lapses	
Frequent Body Complaints	
Body Image Problems	
Repetitive Thoughts	
Repetitive Behaviors	



Are you currently employed?  No  Yes

If yes, who is your current employer/position? \_\_\_\_\_

If yes, are you happy at your current position? \_\_\_\_\_

Please list any work-related stressors, if any: \_\_\_\_\_

Do you consider yourself to be religious?  No  Yes

If yes, what is your faith? \_\_\_\_\_

If no, do you consider yourself to be spiritual?  No  Yes

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

	<u>Yes / No</u>	<u>Family Member</u>
Depression		
Bipolar Disorder		
Anxiety Disorders		
Panic Attacks		
Schizophrenia		
Alcohol/Substance Abuse		
Eating Disorders		
Learning Disabilities		
Trauma History		
Suicide Attempts		

What do you consider to be your strengths?

What do you like most about yourself?

What are effective coping strategies that you've learned?

What are your goals for therapy?

