

Natalie Elkin, MA, IMF

1380 Lead Hill Blvd., Ste. 160 • Roseville, CA 95678 • (916) 505-8529 • IMF60920 • www.natalieelkin.net
Supervised by Sean Davis, PhD, LMFT#45885 • www.drseandavis.com

Individual/Family Information

Name: _____	Date of Birth: _____
Gender: Male Female	Education completed _____ Religion (optional) _____
Occupation _____	Employer _____
Home Address _____	
Home Phone # _____	Work Phone # _____ Cell Phone # _____
<i>Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.</i>	
Spouse/Partner's Name _____	Date of Birth _____
Gender: Male Female	Education completed _____ Religion (optional) _____
Occupation _____	Employer _____
Home Address (if different from above) _____	
Home Phone # _____	Work Phone # _____ Cell Phone # _____
<i>Place an asterisk (*) next to all numbers at which it is okay for me to leave a message.</i>	
Individual/Family combined annual income (circle one)	
\$10-19,999 20-35,999 36-49,999 50-75,999 76-99,999 100-125,000 125,000+	
Number of marriages (including current) for you _____ Your partner _____	
Years of current marriage/relationship _____	

Please list below all children from this or previous marriages/relationships whether or not they live in your household.

<i>Name(s)</i>	<i>Age</i>	<i>Gender</i>

Please list below any medication(s) members of your family are currently taking.

<i>Name</i>	<i>Medication</i>	<i>Dosage</i>

Medical Concerns:

Name of Physician: _____ Phone: _____

Date of last physical: _____

Current Service Providers: _____

Are you willing to sign a release of information for me to coordinate care with them?: yes no

Any Past Service Providers (therapists, psychiatrists, etc.):

Are you willing to sign a release of information for me to coordinate care with them?: yes no

Has anyone being seen ever abused drugs? Yes No If yes, who and which drugs:

Please list below any physical or emotional health problems that members of your family have suffered now or in the past (Include relevant extended family such as parents).

<i>Name</i>	<i>Physical or Emotional Health Problem</i>
_____	_____
_____	_____
_____	_____

Has any member of your family ever participated in counseling or therapy? Yes No

Who? _____

Reason(s)? _____

What led you to end counseling or therapy? _____

Please check any of the following that have been an issue with individuals or relationships in the family:

- | | | |
|--|---|---|
| <input type="checkbox"/> Drinking Problem | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Chronic Stress |
| <input type="checkbox"/> Drug Problem | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Controlling or verbal abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Physical Aggression (pushing, slapping, etc) | <input type="checkbox"/> Parenting Stress |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Financial Difficulties | <input type="checkbox"/> Acting out Children |
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> In-Law or extended family problems |
| <input type="checkbox"/> School Problems | <input type="checkbox"/> Legal Problems | |
| <input type="checkbox"/> Sexual Abuse | | |

What brought you in today?

What are your goals for therapy?

How did you hear about me?

Signature of person filling out form: _____ Date: _____