narrative.
contemporary therapy

928 Fort Stockton Drive, Suite 213, San Diego, CA 92103 ◎ 619-261-4221

Client Information:

Name:_____ Date:_____

Street Address:_____ SSN:_____

City:_____ ZIP:_____ DL:_____

Date of Birth:_____ Age:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

What is the best method to contact you? _____

Do I have permission to leave messages on your:
Home Phone (Y/N), Cell (Y/N), Work (Y/N), and/or Email (Y/N)?

Mental and Psychosocial History:

Have you seen a therapist before? _____ Dates: _____

What issues were addressed at that time? _____

_____

_____

_____

Have you ever been hospitalized for mental illness, chemical dependency, or danger to self or others? If so, when? _____

_____

_____

Do you have a history of drug or alcohol abuse? _____

_____

_____

Have you ever been treated with psychotropic medications prescribed by a medical doctor? __

_____

_____

Are you now taking any prescriptions? _____

_____

_____

Are you under the care of a doctor at this time and for what conditions? _____

_____

_____

Who are you currently residing with? _____

_____

_____

Are there children in the home? _____

_____

_____

Is there a history of child and domestic abuse in the home? _____

_____

_____

For what reasons do you seek therapy at this time? _____

_____

_____

Do you currently have a system of social support, and who is in this system? _____

_____

_____

Have you had a recent change in weight or sleeping patterns? _____

_____

_____

What are your hopes for the following sessions? _____

_____

_____

How did you find our services? (Please circle any that apply)

Referral	Google Search	Craig's List
Yahoo Search	MSN Search	Therapist Unlimited
Counsel-Search	Psychdirectory	Other:_____

Consent to Treat:

I agree to participate in therapy sessions with Erin C. Falvey, Marriage and Family Therapist. I acknowledge that these consultations are related to but not limited to my social context, relationships, life cycle transitions, psychological factors, and belief systems and the connection of these to my mental, emotional, and physical health. I give consent for this treatment. I am also accepting all cost of the sessions and possible fees. These charges are to be paid in full at the time of service. I understand that sessions are scheduled by myself, and that I will incur a fee for any session not cancelled within 24 hours of the appointment. I understand that while therapy is meant to be helpful, it can at times be uncomfortable and difficult.

Client Signature_____ Date_____

Therapist Signature_____ Date_____

Parent Signature (if client is a minor)_____ Date_____