ELANAH D. NAFTALI, DRPH, LMFT
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CLIENT INFORMATION

PATIENT NAME: ____ DATE: ________________

DATE OF BIRTH: ____________ AGE: __________ MARITAL STATUS: _______ NO. CHILDREN _______

STREET ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP: ______________

HOME #: __________________ CELL #: __________________ WORK #: __________________

EMPLOYER /JOB TITLE: ______________________________ OCCUPATION: ______________

HIGHEST DEGREE/ EDUC LEVEL: ______________ Email Address: ______________________

FAITH IDENTITY /SPIRITUALITY: ____

HOW WOULD YOU RATE YOUR PHYSICAL HEALTH? ________________________________

HOW WOULD YOU RATE YOUR QUALITY OF SLEEP? ________________________________

HOW MANY TIMES PER WEEK DO YOU EXERCISE? ________________________________

DO YOU HAVE SPECIAL DIETARY NEEDS /PREFERENCES? ___________________________

DO YOU HAVE ANY CHRONIC PAIN (WHERE /TYPE)? ______________________________

DO YOU DRINK ALCOHOL MORE THAN 1-3X /WEEK? ______________________________

DO YOU USE RECREATIONAL DRUGS? HOW OFTEN? _______________________________

REASONS FOR SEEKING PROFESSIONAL HELP (TELL ME IF YOU'RE IN ANY TYPE OF CRISIS):

____

____

HISTORY OF PROBLEM (INCLUDE APPROX. START DATE, CONTRIBUTING FACTORS):

____

____

MENTAL HEALTH HISTORY / TREATMENT (TX): PLEASE INCLUDE HOSPITALIZATIONS.

TYPE OF EPISODE / PROVIDER NAME	APPROX. YEARS OF TX	ANY ONGOING TX (MEDICATIONS /DOSAGE)

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HEALTH HISTORY / HOSPITALIZATIONS (INCLUDE CHRONIC CONDITIONS LIKE HYPERTENSION, DIABETES, THYROID, & ROUTINE CONCERNS LIKE HEADACHES, STOMACHACHES, PAIN):

CHRONIC CONDITION / PAIN	PROVIDER / TYPE OF TX	CURRENT MEDICATIONS

FAMILY HISTORY OF EMOTIONAL AND/OR DRUG & ALCOHOL RELATED PROBLEMS:

FAMILY MEMBER	MENTAL HEALTH CONDITION	SUBSTANCE USE

SYMPTOM CHECKLIST (CIRCLE ALL THAT APPLY):

DEPRESSED MOOD	LOW ENERGY /FATIGUE	IRRITABILITY	DIZZY /LIGHTHEADED
HOPELESSNESS	SELF-HARMING	OBSESSIVE THINKING	SADNESS
HELPLESSNESS	BINGING /PURGING	PARANOID IDEATION	CHEST PAIN
DISTORTED BODY IMAGE	LOW SELF-ESTEEM	CONDUCT PROBLEMS	FEELING OF CHOKING
TEARFULNESS	ANXIETY	FEARFULNESS	SHORTNESS OF BREATH
MOOD SWINGS	INCESSANT WORRY	SEXUAL DYSFUNCTION	FEAR OF DYING
DIFFICULT CONCENTRATION	PANIC ATTACKS	SEXUAL AROUSAL CHANGE	FEAR OF LOSING CONTROL
DIFFICULTY SLEEPING	ANGER /HOSTILITY	HALLUCINATIONS	DISASSOCIATION

WHAT ARE YOUR HIGHEST HOPES AND DREAMS FOR THIS COURSE OF THERAPY:

____

____

(THANK YOU FOR LETTING ME GET TO KNOW YOU.)