

*Client Information*



(818) 242-0106  
(626) 403-6555

Jessica B. Gillooly, Ph.D.  
Licensed Marriage & Family Therapist  
CA Lic. No. M-13460

Date: \_\_\_\_\_

628 South St. John Avenue  
Pasadena, CA 91105

**A. Identification Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Occupation/Studying: \_\_\_\_\_  
Social Security Number # \_\_\_\_\_

**B. Referral Information**

Who gave you my name to call? \_\_\_\_\_  
May I have your permission to thank this person?  Yes  No

**C. Insurance Information**

Your relationship to Insured?  Self  Spouse  Child  Other  
Insured's Name (if not self): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_ Policy Group #: \_\_\_\_\_  
Employer/School: \_\_\_\_\_  
Insurance Plan Name: \_\_\_\_\_  
Address for Billing Insurance: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**D. Family Information**

Relationship Status:  Single  Married  Partnered  Divorced  Widow/Widower

This is my:  1st  2nd  3rd  4th marriage / partnership

First names of children and their ages: \_\_\_\_\_

Name of Spouse/Partner \_\_\_\_\_

	First Name	Current Age or Age at Death	Illness (Cause of Death)	Education	Occupation
Father					
Mother					
Step Parent(s)					
Maternal Grandparents					
Fraternal Grandparents					
Brothers					
Sisters					

Were your parents  divorced  never married  still married  widowed?

Where are you in the birth order of siblings in your family? \_\_\_\_\_

Family History of:

- Depression
- Suicide
- Anxiety
- Eating Disorders
- Mental Illness
- Violence
- Sexual Abuse
- Emotional Abuse
- Alcoholism/Drug addiction

Any Chronic Illness? If so explain: \_\_\_\_\_

**E. Medical Information**

Primary Physician: \_\_\_\_\_ Last Exam: \_\_\_\_\_

Major (or chronic) Operations / Illness / Injuries: \_\_\_\_\_

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

Current Medications    Dosage (s)    Frequency    Effectiveness    Prescribing Physician

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

Have you experienced any recent changes in:

- Sleep       Nightmares       Amount of Exercise  
 Sexual Desire     Eating / Appetite       Weight

How would you characterize your overall health?

- Poor       Fair       Good       Excellent

Do you smoke?  Yes  No    Did you smoke in the past?  Yes  No  
Packs per day \_\_\_\_\_ Beginning at what age? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you consume alcohol?  Yes  No  
 Less than 1x/mo.     1-3x/mo.     1x/week     Several x's/ week     Daily  
 Beer     Wine     Hard Liquor (Check all that apply)

Do you use street drugs or misuse prescription drugs?  Yes  No

Names of drugs: \_\_\_\_\_

Frequency of use: \_\_\_\_\_

Do you have allergies?  Yes  No

If yes, list: \_\_\_\_\_

**F. Treatment Information**

Please describe the main concern(s) that have prompted you to see me now.

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How have these concerns evolved over time? \_\_\_\_\_

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Please indicate your major life stressors of the past 12 months?

- |  |   |
|--|---|
| <input type="checkbox"/> Serious illness or injury | <input type="checkbox"/> Death of a close friend or family member |
| <input type="checkbox"/> Major illness in family   | <input type="checkbox"/> Gain of new family member                |
| <input type="checkbox"/> Divorce / Separation      | <input type="checkbox"/> Job Change                               |
| <input type="checkbox"/> Other _____               |   |

Please describe what you would like to be different in your life when you are done with therapy.

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Have you ever received psychological or psychiatric counseling before?  Yes  No

When?	From whom?	Purpose?	Results?
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Have you ever been prescribed medication for a psychiatric or emotional problem?

Yes

No

When? Prescribing Clinician? What medication? For what? Results?

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Have you ever been hospitalized for a psychiatric or emotional health reason?

Yes

No

When? Where? For what reason? Outcome?

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Have you ever been in a drug or alcohol treatment program?  Yes  No

Inpatient

Outpatient

Where? How long? Outcome?

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**G. Social / Relationship Information**

Please indicate any of the following that you have experienced.

- Death of mother                      Your age at occurrence \_\_\_\_
- Death of father                      Your age at occurrence \_\_\_\_
- Death of Child                      Your age at occurrence \_\_\_\_    Child's age \_\_\_\_
- Death of Sibling                      Your age at occurrence \_\_\_\_    Sibling's age \_\_\_\_
- Desertion by mother as a child      Your age at occurrence \_\_\_\_
- Desertion by father as a child      Your age at occurrence \_\_\_\_
- Divorce of parents                      Your age at occurrence \_\_\_\_
- Sexual Abuse                       Emotional Abuse                       Physical Abuse
- Violence in the family                       Mental Illness of a family member

How do you get along with your present spouse or partner? \_\_\_\_\_

How do you get along with your children? \_\_\_\_\_

How do (did) you get along with your family of origin members?

Mother? \_\_\_\_\_

Father? \_\_\_\_\_

Siblings? \_\_\_\_\_

Please list the first names of your significant friends and indicate how long you have had these relationships.

First Name	How long?	How often do you see this person?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**H. Employment Information**

What is the nature of your employment? \_\_\_\_\_

How long have you been employed in your current job? \_\_\_\_\_

How satisfied are you in this job?

- Not very satisfied     Somewhat satisfied     Comfortable     Very satisfied

Are you satisfied that the income from your job adequately covers your living expenses?

- Not very satisfied     Somewhat satisfied     Comfortable     Very satisfied

Do you have other sources of income?     Yes     No

Please describe \_\_\_\_\_

\_\_\_\_\_

**I. Spiritual Resources**

How significant a role does spirituality play in your life?

- None     Somewhat Important     Significant     Very Significant

**J. Other**

Is there anything else you think I should know about prior to our beginning your treatment?

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