Diana Mayer, LCMFT
4405 East-West Highway
Bethesda, Maryland 20814
(202) 670- 0427
LCM488

Name: _____ DOB: _____ Marital status: _____

Name of parents/guardians (if a minor):

_____ , _____

Gender: □ Male □ Female **Country of Origin: _____**

Number of Children: _____

Family Composition: (Please list family members residing in your home)

Name:_____ Age:_____

Relationship:_____ Name:_____

Age:_____ Relationship:_____

Name:_____ Age:_____

Relationship:_____ Name:_____

Age:_____ Relationship:_____

Name:_____ Age:_____

Relationship:_____

Local Address:

_____

_____

Phone Number: _____ May we leave a message? □ Yes □ No

Phone Number: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No *Please be aware that email might not be confidential.

Referred by: _____

Are you currently taking prescribed psychiatric medication? □Yes □No If Yes, please list:

_____

Are you currently employed? □ No □ Yes If yes, who is your current employer/position?

_____

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HEALTH AND SOCIAL INFORMATION:

How is your physical health at present? (please circle):

Poor Unsatisfactory Satisfactory Good Very good

Explain: _____

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

How many times per week do you exercise? _____

Are you having any difficulty with appetite or eating habits? □ No □ Yes If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

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? _____

Do you engage in recreational drug use? □ No □ Yes

Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

In the last year, have you experienced any significant life changes or stressors? □ No □ Yes

_____

_____

Have you or a member of your family been exposed to verbal or physical abuse in the last year? □ No □ Yes (If yes please describe)

_____

_____

_____

Are there any weapons in the home? □ No □ Yes

Are you or any of your family members currently experiencing any legal difficulties? (PO, probation, divorce, custody, arrest) □ No □ Yes (If yes please describe)

_____

_____

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OTHER INFORMATION:

The questions below are optional, but they will help me learn a few things about you that may be important to our work together.

How would you like to describe the problem or problems creating difficulties in your life?

_____

_____

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?

_____

_____

_____

_____

_____

_____