CONFIDENTIAL Bijan Amirshahi, Licensed Marriage and Family Therapist & Licensed Professional Clinical Counselor
4000 Barranca Parkway, Suite 250, Irvine, CA 92604 Telephone (949) 533-3177

Today's Date: _____

Name: _____ Birth Date: _____

Home Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ e-mail: _____

Circle the number you prefer me to call you at: Home Cell . Can I leave you a message? At Home ? Y / N - Your Cell? Y / N

You may contact me by e-mail and by text regarding your appointments. Please initial here _____ if you give me the permission to return your e-mails and texts.* _____

* Please note: E-mail and text correspondence are not considered to be confidential media of communication.

Emergency Contact Name: _____ Phone: _____

Gender: M / F Age: _____Your Occupation: _____ Education: _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Years Married (Together): _____ Spouse's (Partner's) Name: _____ His / Her Age: _____

His / Her Education: _____ His /Her Occupation: _____

Children, their names and & Ages: _____

Who referred you? _____

Who do you presently live with? _____

Is this working for you? _____

What brought you here today? _____

What are your goals for counseling? _____

Do you have any fears or concerns about being in counseling? _____

Have you experienced a traumatic event in recent years? If yes please describe. _____
_____

**Are you experiencing stress in any of these areas?**

Grief: _____ Financial: _____

Work: _____ School: _____

Relationships: _____ Family: _____

Legal: _____ Other: _____

**Who are the people you feel emotionally supported by?**

Family: _____ Friends: _____

Spiritually: _____ School: _____

Work: _____ Professionals: _____

Bijan Amirshahi, Licensed Marriage and Family Therapist & Licensed Professional Clinical Counselor
4000 Barranca Parkway, Suite 250, Irvine, CA 92604 Telephone (949) 533-3177

**What is your use of substances?** (approximately)

**Substance** **Amount** **Frequency** **Last Use**

Alcohol: _____

Prescription: _____

Recreational Drugs: _____

Other: _____

Do you have a history of Seizures _____ Hallucinations _____ Blackouts _____ Scary Thoughts _____

Confusion _____ Tremors _____ Other _____

**Previous Counseling Experience – Outpatient / Inpatient**

When With Whom: Where: Frequency: Diagnosis

_____

_____

_____

Are you currently working with any other doctor, therapist, psychologist, group, etc.? Y / N

If Yes, explain: _____

May I contact them? Y / N Name: _____ Phone: _____

Y / N Name: _____ Phone: _____

Have you taken any psychiatric medications in the past at any time?

Antidepressants: _____ Antianxiety: _____ Antipsychotics: _____

**Medical History**

Current Medical Problems: _____

Name of Physician: _____

Could I contact them to coordinate your care, if necessary? Y / N Phone #: _____

Are you currently taking any medications? For What Dosage

_____

_____

**Have you experienced any of the following in the past year?**

[ ] Fatigue / Sleep Disturbance: _____

[ ] Depression / Extreme Sadness: _____

[ ] Loss of Interest in Daily Activity: _____

[ ] Panic / Anxiety: _____

[ ] Decreased Concentration / Memory Loss: _____

Bijan Amirshahi, Licensed Marriage and Family Therapist & Licensed Professional Clinical Counselor
4000 Barranca Parkway, Suite 250, Irvine, CA 92604 Telephone (949) 533-3177

**Have you experienced any of the following in the past year?** *(continued)*

[ ] Mood Swings: _____

[ ] Weight Gain / Loss: _____

[ ] Excessive Worthlessness / Guilt: _____

[ ] Paranoia / Obsessive Behavior: _____

[ ] Isolation / Loneliness: _____

Have you ever attempted or seriously considered suicide? _____

When? _____

Have you ever engaged in self-mutilation/cutting/burning? Y / N Specify how? _____

Have you any concerns about your sexuality with your partner or for your partner or for yourself? Y / N

Any: [ ] Heart Palpitation [ ] Difficulty Breathing [ ] Stomach Problem [ ] Diabetes [ ] Other _____

Any disabilities including visual / auditory? Y / N Describe: _____

**Your family of origin information:**

| | Father | Mother | Brother or Sister | Brother or Sister | Brother or Sister | Brother or Sister | Brother or Sister |
|---|---|---|---|---|---|---|---|
| Name | | | | | | | |
| Age | | | | | | | |
| Education | | | | | | | |
| Occupation | | | | | | | |
| History of Mental Illness if any | | | | | | | |

*Thank you very much for taking the time and care to complete this form.*