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CLIENT INFORMATION

Name of person initiating therapy: _____ Date: _____

Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ California DL#: _____

Home phone: _____ Cell: _____ Work: _____

Calls will be discreet at work and home. Please list any restrictions.

Please email me appointment reminders

Please email me your health and wellness monthly newsletter (1x month)

Occupation: _____

Relationship Status:

Single Married Domestic Partnership

Divorced Widowed Other: _____

Number of times married: Self _____ Spouse _____ Years married _____

Name(s) of others who will be attending sessions:

1) Name: _____ Birthdate/Age: _____

Relationship: _____ Phone: _____

Address (if different): _____

2) Name: _____ Birthdate/Age: _____

Relationship: _____ Phone: _____

Address (if different): _____

3) Name: _____ Birthdate/Age: _____

Relationship: _____ Phone: _____

Address (if different): _____

Who currently lives in your home? _____

Who referred you? _____

May I have permission to thank that person? _____

EMERGENCY INFORMATION

Name of your primary care physician: _____

Date of last check-up or doctor's visit: _____

Phone: _____

Name of your psychiatrist (if applicable): _____

Phone: _____

Name of emergency contact: _____

Phone number(s): _____

AUTHORIZATION TO TREAT:

I authorize and direct Dani Graziano, MFT, to perform such therapeutic procedures that her professional judgment may indicate to be advisable for my well-being. I understand that no warranty or guarantee is made as to the results of this treatment. I agree to assume financial responsibility for the regular fee charged for a failed appointment canceled with less than 24 hours notice.

Date _____ Signed _____

ADULT PSYCHOSOCIAL HISTORY

Presenting Problem(s):

Please state the problem or problems which brought you to counseling.

When did these problems begin? (the best that you can remember)

What do you hope to achieve? How do you want me to help?

Family of Origin:

Were your biological parents married? Yes No

Are your biological parents still married? Yes No

If divorced, how old were you? _____

How many brothers do you have? _____ How many sisters do you have? _____

Which child were you in the birth order? _____

If you were not raised by your biological parents, who raised you? _____

Has anyone in your immediate family died? Yes No

If so, who? _____

Does anyone in your immediate family have a problem with alcohol, drugs or mental health? Yes No

If yes, who? _____

Other problems? _____

How would you describe the relationship your parents or guardians have (had) with each other?

- Cold - Distant
- Stormy - Arguments
- Loving - Close
- Tolerant – Put up with each other
- Abusive – verbal and/or physical fights

How would you describe the relationship between you and your partner?

- Cold - Distant
- Stormy - Arguments
- Loving - Close
- Tolerant – Put up with each other
- Abusive – verbal and/or physical fights

How would you describe the relationship between you and most of the partners you have been involved with?

- Cold - Distant
- Stormy - Arguments
- Loving - Close
- Tolerant – Put up with each other
- Abusive – verbal and/or physical fights

How would you describe the relationship with you and your mother?

- Cold - Distant
- Stormy - Arguments
- Loving - Close
- Tolerant – Put up with each other
- Abusive – verbal and/or physical fights

How would you describe the relationship between you and your father?

- Cold - Distant
- Stormy - Arguments
- Loving - Close
- Tolerant – Put up with each other
- Abusive – verbal and/or physical fights

How would you describe the relationship between you and your partner's family?

- Cold - Distant Stormy - Arguments
 Loving - Close Tolerant – Put up with each other
 Abusive – verbal and/or physical fights

Abuse

Check any of the following that has happened to you or an immediate family member.

- Verbally abused Self Family member by whom: _____
 Physically abused Self Family member by whom: _____
 Sexually harassed Self Family member by whom: _____
 Sexually abused Self Family member by whom: _____
 Raped Self Family member by whom: _____

Including yourself, has anyone in your immediate family been thinking about suicide, planning suicide, or made a suicide attempt in the last 6 (six) months?

Health

- I am in excellent health I am in good health I am in fair health
 I am in poor health

Have you ever been in the hospital? Yes No

What were you treated for? _____

Have you ever seen a professional therapist? Yes No

If yes, when? _____

Do you have any current health concerns or a medical condition that is being treated by your medical doctor that I should be aware of? _____

Prescription drug(s), including birth control pills, that you are currently taking:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Supplements, vitamins and/or herbs that you are currently taking:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

How often do you consume the following?

Cigarettes _____

Coffee _____

Soda _____

Alcoholic beverages _____

Street drugs (please list what and how often): _____

How often do you exercise? _____

What form(s) of exercise do you engage in (i.e. yoga, swimming, biking, weights)?

School

Highest level of education completed?

- Grade school High School College Graduate degree Other

What kind of grades did you usually make?

- A's B's C's D's F's

Religion/Community Support

Do you participate in any community or social activities or organizations?

Yes No

If yes, please list: _____

Is there someone with whom you can share your problems? Yes No

If yes, whom? (spouse, friend, sibling) _____

Do you have a religious/spiritual affiliation? Yes No

How important are spiritual concerns in your life? _____

Behavior: (check all that apply to you)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Lose Control | <input type="checkbox"/> Cry | <input type="checkbox"/> Can't eat |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sleep all the time | <input type="checkbox"/> Overspend | <input type="checkbox"/> Stay by myself |
| <input type="checkbox"/> Work too hard | <input type="checkbox"/> Avoid fearful things | <input type="checkbox"/> Can't sleep | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Often put things off | <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Lazy | <input type="checkbox"/> Quit jobs |
| <input type="checkbox"/> Act on Impulse | <input type="checkbox"/> Do things over and over | <input type="checkbox"/> Get mad often | <input type="checkbox"/> Problems with friends |

Feelings: (check all that apply to you)

- | | | | | | |
|----------------------------------|------------------------------------|-------------------------------------|------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Happy | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Annoyed | <input type="checkbox"/> Guilty | <input type="checkbox"/> Excited |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Ashamed | <input type="checkbox"/> Depressed | <input type="checkbox"/> Confused | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Regretful | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Fearful | <input type="checkbox"/> Bored | <input type="checkbox"/> Helpless |
| <input type="checkbox"/> Panicky | <input type="checkbox"/> Restless | <input type="checkbox"/> Numb | <input type="checkbox"/> Energetic | <input type="checkbox"/> Lonely | <input type="checkbox"/> Jealous |
| <input type="checkbox"/> Envy | <input type="checkbox"/> Contented | | | | |

Thoughts: (Check all that apply to you)

- | | |
|---|---|
| <input type="checkbox"/> I am not very smart. | <input type="checkbox"/> I am worthless, a nobody, useless. |
| <input type="checkbox"/> I am ugly, unattractive. | <input type="checkbox"/> I am confused and cannot think clearly |
| <input type="checkbox"/> I make friends easily. | <input type="checkbox"/> People do not like me. |
| <input type="checkbox"/> People pick on me. | <input type="checkbox"/> There are people who want to hurt me. |
| <input type="checkbox"/> Life is really not worth living. | <input type="checkbox"/> I have difficulty making friends. |
| <input type="checkbox"/> I constantly make mistakes, can't do anything right. | |
| <input type="checkbox"/> I think life is very serious and people should take it that way. | |

Alcohol use:

- | | | |
|---|------------------------------|-----------------------------|
| Have you felt you should cut down on your drinking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have people annoyed you by criticizing your drinking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever felt bad or guilty about your drinking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had a drink first thing in the morning to steady your nerves? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had blackouts as a result of drinking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has drinking ever played a part in family arguments? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Including yourself, has any member of your family been drinking excessively or experienced any alcohol or drug related incidents such as DUI, missed work because of intoxication or hangover, arrest, or medical problems related to alcohol or drug use?
