Elisa M. Thomas MA, LMFT
1487 W. State Route 89A, Suite #7
Sedona, AZ 86336
(928)-202-1767

Client Information

Name of Client:_____
Male:_____Female:_____ Date of Birth:_____Age_____

Address/Zip Code_____

Home Tel. #:_____ Cell #:_____
Tel. # preferred to receive calls back with confidential information Home: ___ Cell:___

Email Address:_____

Occupation:_____

Person to call in case of emergency:_____Relationship:_____

Their Tel. #:_____

Are you feeling suicidal now? No: ___ Yes:___

Spouse/Partner Information:

Name:_____Age:_____

Occupation:_____

Tel#:_____ Cell#:_____

Are you married to this person? Yes_____ No_____ How long have you been together?_____

Family Information:
Children's names and ages_____ Age_____

_____ Age_____Occupation:_____

_____ Age_____Occupation:_____

_____ Age_____Occupation:_____

_____ Age_____Occupation:_____

Medical information:
Current Health Issues:_____

_____

Primary care Physician:_____ Tel.#:_____

Current Medications:_____

_____

Are you now or have you ever been on medication for psychological related reasons? (If so, name the medication, dosage and frequency taken and when)_____

_____

Are you under the care of a doctor or psychiatrist now? Yes_____ No_____
If so, name and address of psychiatrist_____

_____

May I contact this person if I believe it would be therapeutically beneficial for your continued care?_____
Have you ever been hospitalized for psychological reasons?_____

Diagnosis given:_____

Have you ever attempted suicide?_____ How many times?_____

When did this happen?_____

Medical History: (Any known diseases, accidents, trauma, hospitalizations, major operations,

etc.)_____

_____

_____

Do you have any concerns about your eating patterns and/or weight?_____

Do you have a history of bulimia (purging or vomiting after eating) or anorexia (restricting eating)?_____

If so, how old were you when it started? _____What treatment did you get? _____

_____

Is this behavior still happening? _____Are you worried that it might continue?_____

Please describe your current mood and approx. how long this has been the case:_____

_____

Please describe your current or past use of alcohol or other drugs (type, amount, frequency and what happens to you when you use:

_____

_____

_____

Have you ever blacked out? _____ When?_____

Have you participated in 12 Step recovery programs?_____Which ones?_____

When?_____ Approximately how long have you been sober?_____

Are you reluctant to confide in others because you believe that they are plotting against you?_____

Do you find that you prefer to be alone, not wanting or enjoying the companionship of others and feeling indifferent, unable to take pleasure in most activities?_____

Explain_____

Have you seen things or heard voices that others cannot see or hear?_____

Explain_____

Are you currently involved in a relationship where there is physical violence or abusive acts? If yes,

please explain_____

Previous Therapy:

Are you currently in therapy? Yes_____ No_____What kind?_____

Have you been in therapy before? Yes_____ No_____ When?_____

Type of therapy: (Individual, couples, family, group, etc.)_____

Therapist's Name and Location:_____

_____

May I contact this therapist if I determine that it would be therapeutically beneficial for you?_____

Who were you referred by today?_____

Reason for coming to therapy today and goals you would like to achieve:_____

_____

_____

_____