DR CASSIDY FREITAS LMFT

MFC No.91256

Individual Intake Questionnaire

Today's Date: _____

Note: If you have been a client before, please fill in only the information that has changed.

A. Identification

Name: _____ Date of Birth: _____ Age: _____

Nicknames/Aliases: _____ Email: _____

Home Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Calls will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes ☐ No ☐

How did this person explain how I might be of help to you? _____

_____

_____

C. Chief Concern

Please describe the main difficulty that has brought you to see me: _____

_____

_____

Have you ever had any of the following problems?

Head Injuries	Yes ☐	No ☐		High blood pressure	Yes ☐	No ☐	
Stroke	Yes ☐	No ☐		Heart disease	Yes ☐	No ☐	
Cancer	Yes ☐	No ☐		Meningitis	Yes ☐	No ☐	
Diabetes	Yes ☐	No ☐		Loss of consciousness	Yes ☐	No ☐	
Thyroid Disease	Yes ☐	No ☐		Severe/Frequent headaches	Yes ☐	No ☐	
Alcoholism	Yes ☐	No ☐		Drug problems	Yes ☐	No ☐	
Sleep disturbances	Yes ☐	No ☐		Depression	Yes ☐	No ☐	
Fainting/Dizziness	Yes ☐	No ☐		Anxiety	Yes ☐	No ☐	
Convulsions	Yes ☐	No ☐		Problems with sex	Yes ☐	No ☐	
Memory Problems	Yes ☐	No ☐		Extreme tiredness	Yes ☐	No ☐	
Hallucinations	Yes ☐	No ☐		Heart palpitations	Yes ☐	No ☐	
Crying spells	Yes ☐	No ☐		Suicidal thoughts	Yes ☐	No ☐	
Appetite Changes	Yes ☐	No ☐		Difficulty concentrating	Yes ☐	No ☐	

Cassidy Freitas, Ph.D., LMFT Lic # MFC 91256

3355 Fourth Avenue San Diego, CA 92103 Phone: (619) 214-4843

Email: cassidy@drcassidymft.com

www.drcassidymft.com

D. Treatment

1. Have you ever received psychological or psychiatric or counseling services before?
   Yes ☐ No ☐ If yes, please indicate:

When?	From whom?	For what?	Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever taken medications for psychiatric or emotional problems?
   Yes ☐ No ☐ If yes, please indicate:

When?	From whom?	Medication	For what?	Results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

E. Family History

Have any of your BLOOD RELATIVES ever had any of the following:

			WHO?
Alcoholism	Yes	No	_____ _____
Depression	Yes	No	_____ _____
Mental Illness	Yes	No	_____ _____
Epilepsy	Yes	No	_____ _____
Neurological Disorder	Yes	No	_____ _____
Suicide Attempts	Yes	No	_____ _____
Hallucinations	Yes	No	_____ _____
Drug Problems	Yes	No	_____ _____
Psychiatric Treatment	Yes	No	_____ _____

F. Significant Relationships

	Name of person	Your age when started	Person's age when started	How long	Reason for ending
Current	_____	_____	_____	_____	
First	_____	_____	_____	_____	_____
Second	_____	_____	_____	_____	_____
Third	_____	_____	_____	_____	_____

G. Current Living Situation

1. Please describe your current living situation, including any family members or roommates living with you:_____
   _____
2. Children (and ages): _____
   _____

H. Education/Employer (or for child, parent's current employer)

Highest grade/degree completed? _____ College/Graduate Major(s):_____
Employer: _____ Occupation: _____
Address: _____ Phone: _____