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Aloha and welcome to my practice. Please fill out this form and bring it to your first session.

Please note: information you provide here is protected as confidential information.

Date: _____

Name: _____
(First) (Last) (Middle Initial)

Name of parent/guardian (if under 18 years):

(First) (Last) (Middle Initial)

Birth Date: ____ / ____ / ____ **Age:** ____ **Gender:** M F **SS#** _____

Address: _____
(Street and Number)

(City) (State) (Zip)

Home Phone: () May I leave a message? Yes No

Cell/Other Phone: () May I leave a message? Yes No

E-mail: _____ May I email you? Yes No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status: Never Married Living together Married Separated Divorced Widowed

On a scale of 1-10, how would you rate your relationship? _____

Please list any children/age(s): _____

Emergency Contact: _____ **Relationship** _____

Phone of Emergency Contact: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes, previous therapist/practitioner: _____

Have you ever been prescribed psychiatric medication? Yes No Please list & provide dates: _____

Referred by (if any): _____ May I thank them? Yes No

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific/ chronic health problems:

2. Physician name & phone number _____

3. Date of last physical examination _____

4. Are you currently taking any prescription medications? Herbal or natural supplements?

Please list type & amounts: _____

6. How often do you drink alcohol? _____ How much? _____

7. Do you or have you ever engaged in any recreational drug use?

Daily Weekly Monthly Infrequently Never

8. What significant life changes or stressful events have you experienced recently: _____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member(s)
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION

1. Are you currently employed? No Yes

If yes, what is your current employment situation/ position:

2. Do you consider yourself to be spiritual or religious? No Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What would you like to accomplish out of your time in therapy?

5. Is your visit related to or may it become related to any legal proceedings? Law suits? Disability claims in the present or future? _____

Is there anything else you I need to know or you would like for me to know? _____
