Blair Wellington, LPC, MFT
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415.517.7051
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Client Name: _____

Date of Birth _____

Gender: _____ Ethnicity: _____ How you found me (Internet, Yelp etc): _____

Home phone: _____ Work phone: _____
OK to leave message? ___yes ___no OK to leave message? ___yes ___no

Mailing Address: _____

City/State/Zip: _____

Emergency Contact: _____
Name Phone

Occupation: _____ Employer: _____

Relationship status: single/never married partnered married divorced separated widowed

Living Situation: alone spouse/partner parents roommate(s) children

Name, age, and relationship of others in the home: _____

_____

_____

Primary Care Provider: _____ Phone: _____

Last Physical Exam: _____ First time in therapy? _____

Medical History (please circle):

		High blood pressure	STD	Heart problems	HEP/Liver
Sleep problems	Surgeries	Loss of consciousness	TB	Urinary problems	Diabetes
Skin problems	Asthma	Appetite/Weight change	W/drawl seizures	Thyroid problems	Pregnancy
Vision problems	Drug reactions	Head injury	Seizures	Kidney disease	Prosthesis
Hearing problems	Allergies _____		Other Diagnosis: _____		

Substance Use: please circle (present = in the past 2 weeks):

	Present		Past			Present		Past			Present		Past			Present		Past	
Tobacco	Y	N	Y	N	Alcohol	Y	N	Y	N	Cocaine	Y	N	Y	N	Marijuana	Y	N	Y	N
Caffeine	Y	N	Y	N	Amphetamines	Y	N	Y	N	Hallucinogens	Y	N	Y	N	Sedatives	Y	N	Y	N
										PCP	Y	N	Y	N	Opiates	Y	N	Y	N

Current Medications (Prescribed & Over the Counter)	Dosage/frequency	Prescribed by	Date 1ST prescribed	Last dose

(continued on reverse)

In the past 3 months have you experienced significant symptoms of (please circle):

Aggression	Crying	Fear	Irritability	Self-destructive relationships
Anger	Denial	Flashbacks	Memory problems	Self harm behaviors
Anxiety	Depression	Guilt	Nightmares	Sexual acting out
Apathy	Difficulty concentrating	Harm or threat to others	Obsessive behavior	Somatic (body) complaints
Avoidance	Disordered eating patterns	Hyperactivity	Panic	Substance abuse
Behavior problems	Dissociation	Hyperarousal	Phobias	Other: _____
Compulsive behavior	Emotional numbing	Insomnia/sleep problems	Self-blame	_____

Authorized Signature: I authorize the release of any medical or other information necessary to process appropriate insurance claims. I authorize payment of mental health benefits to Blair Wellington, MFT.

Signed: _____ Date: _____