

Deborah Moyer, LMFT License #86357  
11440 West Bernardo Court, Suite 200  
San Diego, CA 92127  
858-731-6013

**General:**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_ Date of birth \_\_\_\_\_ Occupation \_\_\_\_\_ Marital status \_\_\_\_\_

Emergency contact information \_\_\_\_\_

Contact preferences:

Phone: \_\_\_\_\_

- Do not Use     OK to Use     Preferred  
 OK to leave voicemail

Text messaging: \_\_\_\_\_ or  Same as phone

- Do not Use     OK to Use     Preferred

Email: \_\_\_\_\_

- Do not Use     OK to Use     Preferred

How did you hear about Deborah? May I thank them for referring you?

\_\_\_\_\_

**Areas of Concern**

What issues/concerns cause you to seek treatment? Please describe.

Do you have any specific goals with regard to your treatment?

Do you have any particular concerns/fears with regard to treatment?

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**Psychological History:**

Have you ever received mental health treatment before? When and for how long? What was the focus of treatment?

Are you currently in therapy? If so, please provide the name of treating therapist(s), address(es), telephone number(s)

Have you ever taken any medications for a mental or emotional condition? When, what and for how long?

Have you ever been hospitalized for mental or emotional problems? When and for how long? Why were you hospitalized?

Have you ever attempted suicide? When? Describe the circumstances that led to that attempt.

Are you currently having any suicidal thoughts? Please describe.

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe.

Have you experienced other trauma? Please describe.

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## Medical History

Have you ever been diagnosed with a serious illness? Please describe.

Are you currently taking any prescription medications? Prescribed by whom?  
How long have you been on the medications?

Do you have any medical conditions that may affect your mental health treatment?

Please describe your overall health today. Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe.

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_

On average, how much alcohol do you consume in a week? \_\_\_\_\_

Do you use marijuana? \_\_\_\_\_

On average, how much marijuana do you consume in a week? \_\_\_\_\_

Do you currently use illegal drugs? Please describe.

Have you ever used illegal drugs? Please describe.

Have you ever been in a 12-step program? Please describe.

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### **Current Relationship History**

If you are currently in a relationship, please describe, including how long you've been together and what the relationship has been like. Please include the first names and ages of biological and stepchildren you share.

Please also provide similar information for any previous significant relationships you have had.

### **Family of Origin History**

Please describe your childhood. Please include first names and ages of your parents and siblings, and whether they are living or deceased. Please describe your relationships with your family members.

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**Other Information**

Please describe your spiritual identity/orientation, and whether or not you wish to incorporate this into your therapy.

Please describe your interests/hobbies.

Are you now or have you ever been involved in a lawsuit? Please describe.

Please feel free to include any other information that you believe is relevant to your mental health treatment, not previously requested.