Orange County Family Therapy
Individuals* Couples* Families* Adolescents* Marriage

Dr. Vennus Zand, Psy.D., LMFT #84766
(949) DIAL-MFT (949) 342-5638
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Initial Intake Form

A. Identification

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

Date of Birth: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Other

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

_____
(Last) (First) (Middle Initial)

Marital Status: □ Never Married □ Domestic Partnership/Civil Union □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address:_____
(Street and Number) (City) (State) (Zip-Code)

B. Contact Information

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( )_____ May we leave a message? □ Yes □ No
May we send a text message □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact Name: _____
Relationship to you? _____
Phone Number: _____
*Please note: If you do not provide an emergency contact you are allowing your therapist to contact 911 or other emergency responders in the event of an emergency

C. Referral

Referred by: _____Phone:_____
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? _____
_____

D. Employment/School Information

Are you currently employed? □ No □ Yes
If yes, what is your current employment situation: □ Full Time □ Part-time □Unemployed
□ On Disability □ Minor/not employed
Job Title: _____

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Employer Name: _____Phone:_____

If Student: □ Full-time □ Part-time
School/College Name: _____
Do you enjoy your work/school? □ No □ Yes
Is there anything stressful about your current work/school?
_____

E. Health and Mental Health Information
Name of Primary Care Physician (PCP):_____Phone:_____

PCP Address: _____
(Street and Number) (City) (State) (Zip-Code)

□ **I do** / □ **I do not** wish for my PCP to be occasionally informed about my treatment

Signature: _____ Relationship to patient: _____Date: _____

Are you currently taking any prescription medication? □ Yes □ No
Please list: _____

_____

Do you have any allergies? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes Name of Therapist(s):_____
Have you ever been prescribed psychiatric medication? □ Yes □ No
Please list and provide dates: _____

_____
How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:
_____
How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

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Please list any difficulties you experience with your appetite or eating patterns:
_____

Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe _____

Do you drink alcohol more than once a week? □ No □ Yes
If yes, please say about how many drinks per week:_____

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

F. Romantic Relationships
Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?_____

On a scale of 1(low) to 10 (high), how would you rate your relationship? _____

G. Family Mental Health Information:
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.). If you identify with any of the following please print SELF.

	Please Circle	List Family Member
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	_____

Have you or anyone in your family had any psychiatric hospitalizations? □ No □ Yes
If yes, please indicate: Diagnosis/condition, Name of hospital, and Dates of treatment
_____
_____
Have you or anyone in your family had suicidal thoughts / attempts / self-harm (cutting, carving etc.) recently or in the past? □ No □ Yes
If yes, please indicate: Name, Circumstances, and Dates
_____
_____

H. Religious/Spiritual Information
Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:
_____

I. Ethnic/Racial Identification
Ethnicity/National Origin: _____ Race: _____

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J. Additional Information:

What are the primary reasons for which you are seeking therapy?

_____
_____

What are the most important things you think I should know about these issues?

_____
_____

In what ways have you attempted to cope with these issues?

_____
_____

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

_____
_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____
Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

What do you consider to be some of your strengths?

_____
_____

What do you consider to be some of your weakness?

_____
_____

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

_____
_____

Is there any other information you would like me to know?