# Scott Seomin

Licensed Marriage & Family Therapist MFC 90578

## Client Intake Questionnaire

Please fill in the information below and bring
it with you to your first session.

### Personal Information

Today's Date: _____

Name:_____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ May I leave a message? ◯ Yes ◯ No

Cell Phone:_____ May I leave a message? ◯ Yes ◯ No
May I send texts? ◯ Yes ◯ No

Work or Other Phone:_____ May I leave a message? ◯ Yes ◯ No

Email:_____ May I email you? ◯ Yes ◯ No

Date of Birth: _____Age: _____ Gender:_____

**Preferred Pronouns:** ◯ He/Him/His ◯ She/Her/Hers ◯ They/Them/Theirs

**Marital Status:**

◯ Never Married ◯ Domestic Partnership ◯ Married
◯ Divorced ◯ Widowed ◯ Separated

Referred By (if any):_____

7257 Beverly Boulevard, Suite 108, Los Angeles, CA 90035 323 656 3337

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## History

Have you previously received any type of mental health services, such as psychotherapy, psychiatric services, etc.?

◯ No  Yes, previous therapist/practitioner:_____

Are you currently taking any prescription medication? ◯ Yes ◯ No

If yes, please list:_____

_____

_____

_____

Have you ever been prescribed psychiatric medication? ◯ Yes ◯ No

If yes, please list and provide dates:

_____

## General & Mental Health Information

How would you rate your current physical health?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

_____

How would you rate your current sleeping habits?

◯ Poor ◯ Unsatisfactory ◯ Satisfactory ◯ Good ◯ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

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How many times per week do you generally exercise?_____
What types of exercise do you participate in? _____

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

_____

Are you currently experiencing overwhelming sadness, grief or depression? ◯Yes ◯No
If yes, for approximately how long?_____

Are you currently experiencing anxiety, panic attacks or have any phobias? ◯Yes ◯No
If yes, when did you begin experiencing this?_____

_____

Do you drink alcohol more than once a week? ◯Yes ◯No

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

Are you currently in a romantic relationship? ◯Yes ◯No
If yes, for how long?_____

On a scale of 1-10 (1 being poor and 10 being exceptional), how would you rate this romantic relationship?
◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

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

_____

_____

_____

Emergency Contact:
Name: _____
Phone: _____
Relationship: _____

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