Beth Kanne-Casselman, MEd, MFT 805.895.6960

Licensed Marriage Family Therapist

bethkannecasselman@gmail.com MFC41818

This information is maintained in confidence in your record. Disclosure of information only occurs with express written permission via a Release of Information form.

Review of Concerns

ADULTS/COUPLES

Children: Some of this information is very helpful in the treatment of children. Please look it over and include anything relevant for working with your child/children. Thank you.

(For couples, please each complete the following form. **For parents, please include family information that would be helpful to know as it pertains to your child.**)

Today's Date:

Who referred you to me?

A. Identification Name & Pronouns: Date of Birth: Address:

Phone: Email address: Please indicate any phone restrictions: Please note if there is more than one address and telephone number.

B. Current Relationship status:

Married Single Divorced Widowed Separated Long-term relationship

How do you get along with your current spouse or partner?

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C. Marital / Significant Other Relationship History

Age at onset Duration involved Married / Live together when and for how long Reason for ending

D. Children (Please indicate which are from a previous marriage or relationship) Name & Pronouns Current age Gender

School Grade Attends what school, preschool, or day care Concerns

Name & Pronouns Current age Gender School Grade Attends what school, preschool, or day care Concerns

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E. Most Recent Former Therapist / Psychiatrist: If you would like us to speak, please complete a Release. Name: Date last visited: Address: Phone: Please indicate any phone restrictions:

Treatment History:

Have you ever received psychological, psychiatric or psychiatric hospitalization services before? yes no Please describe:

When? From whom? For what? What were the results? Have you ever been depressed? Please explain:

Have you ever felt very anxious? Please explain

No contact will be made with any former doctors or therapists without express written permission.

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F. List any medications currently or previously taken for psychiatric or emotional concerns: *When?*

Prescribing Physician Medication Name To address what? Results?

G. Abuse History:

I was not abused in any way. ___ I was abused. ___ If you were abused please indicate the following:

P=physical, S=sexual, E=emotional, N=neglect Age experienced abuse:

Who abused you?

Effects on you?

Who did you tell?

H. Substance Use:

Have you ever felt the need to cut down on your drinking or substance use? yes no Have you ever felt annoyed by criticism of your drinking or substance use? yes no

Have you ever felt guilty about your drinking or substance use? yes no Have you ever taken a morning “eye opener”? yes no

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Have you ever had any legal issues due to drinking or substance use? yes no

How much alcohol do/did you consume a week on average?

How much tobacco do/did you consume a week on average?

How much of other substances do/did you consume a week on average?

Which drugs (other than prescribed medications) have you used in the last ten years?

Please provide details:

I. Primary Concern:

Please describe the main difficulty that has brought you to see me:

J. Relationships in your life:

Please describe: Your parents' relationship with each other:

Your early attachment to your parent/s or immediate caregivers:

Your or your family health problems, chemical use, mental or emotional difficulties:

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Your relationship with your siblings, past and present:

Your relationships with your children:

Your support network of friends: Names

Strengths of your relationship/s: Challenges of relationship/s:

K. Current Employment status:

Employed: FT / PT Student Unemployed Other

What type of work do you do?

L. Education History

Dates School/s Adjustment to school Did you graduate?

M. Other Information

Please indicate any other significant information you would like me to know. Are there any other pertinent issues or concerns you would like to share, including legal matters, custody issues, symptoms, health condtions, etc:

N. What do you hope to gain from therapy?