Beth Kanne-Casselman, MEd, MFT 805.895.6960
Licensed Marriage Family Therapist bethkannecasselman@gmail.com
Developmental & Educational Consulting
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

(For couples, please each complete the following form.)

Today's Date:

A. Identification
Name:
Date of Birth:
Address:
Phone:
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
Longterm relationship

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

C. Marital / Significant Other Relationship History
Age at onset

Duration involved

Married / Co-Habitated when and for how long

Reason for ending

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D. Children (Please indicate which are from a previous marriage or relationship)
Name
Current age
Gender
School Grade
Attends what school, preschool, or day care
Concerns

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

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

E. Most Recent Former Therapist / Psychiatrist:
Name: **Date last visited:**
Address:
Phone:
Please indicate any phone restrictions:

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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 without express written permission*.**

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

Prescribing Physician

Medication Name

To address what?

Results?

G. Primary Concern:
Please describe the main difficulty that has brought you to see me:

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H. 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:

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:

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I. Current Employment status:
Employed: FT / PT
Student
Unemployed
Other
What type of work do you do?

J. Education History
Dates
School/s
Adjustment to school
Did you graduate?

K. 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?

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L. 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
Have you ever had any legal issues due to drinking or substance use? yes no
How much alcohol do you consume a week on average?
How much tobacco do you consume a week on average?
How much of other substances do you consume a week on average?
Which drugs (other than prescribed medications) have you used in the last ten years?
Please provide details:

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?