EMERGE, LLC
Personal & Relationship Coaching and Enrichment

Name:_____ **Date of Initial Evaluation:** _____

Age: _____ **Date of Birth** _____ **Gender** M or F

E-mail Address:_____ **Social Security #:** _____

Contact Information

HomeAddress:_____

MailingAddress:_____

Phone Numbers:(Home)_____**(Cell)**_____**(Work)** _____

May I leave a message for you at these numbers? _____

Relationship Status: _____ **Spouse/Partner Name:** _____

Education Level (*circle one*): HS Bachelor Master Doctorate

Emergency Contact Name/Phone Number: _____

Employment Information

Place of Employment: _____**Occupation:** _____

Guardian Information (*completed only if Client is a Minor*)

Mother: _____ **Phone:** _____
Address: _____
_____

Father: _____ **Phone:** _____
Address: _____
_____

Parent's Relationship Status (Circle One)
Married Separated/Pending Divorce Divorced Never Married Living Together

Current Custody (Circle One) JOINT SOLE SPLIT

Current TimeSharing Arrangement:
Mother: _____ **Father:** _____

Family Composition

Please list all family members living in the household.

Name	Age	Gender	Relationship

Medical Information

History of Medical Conditions: (*e.g.,Diabetes, Hypertension, Cardiac Issues, Asthma, Cancer Head injury, Seizures, etc):*

_____

_____

Current Health Condition	Medications	Treating Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of last physical examination? _____ **Physician:** _____

Any psychiatric hospitalizations? Yes _____ **or No** _____. **If yes, when** _____

Reason for hospitalizations: _____

Substance Abuse History

Substance	Amount	Frequency	Duration	First Use	Last Use	Never Used
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Other(s)						

Briefly describe the reason for your appointment.

_____

_____

_____

_____

What do you hope will change by participating in therapy?

_____

_____

_____

_____

Referral Information

How did you hear about Charmaine M. Smith, LMFT and/or EMERGE, PLLC?

_____ **Court Referral**

_____ **Internet**

_____ **Doctor/Psychiatrist**

_____ **Other (Please specify_____)**

_____ **Mental Health Professional**

_____ **Employer/EAP**

_____ **Attorney**

I freely give my permission for the therapy to be received. I understand payment is due at the time of service unless prior arrangement have been made. I understand that if I do not cancel an appointment 24 hours in advance, I will be responsible for the full amount of that session. All payments shall be made in the form of cash, check, or electronic debit or credit card.

Client/Guardian Signature: _____ **Date:** _____

If Guardian, what is your relationship to the client? _____

INTAKE Client Self-Assessment

Please circle the description that is most appropriate for you.

MOOD
Extreme Depression Feeling Low or Down Content Happy Extremely Happy

SENSE OF PLEASURE AND INTEREST IN ACTIVITIES
None Poor Average Good Excellent

FEELINGS OF GUILT
Excessive Some Little Rare None

ENERGY LEVEL
None Poor Average Good Excessive

CONCENTRATION
Extremely Poor Poor Average Good Excellent

SLEEP
Extremely Poor Poor Average Good Excessive

APPETITE
None Poor Average Good Excessive

Have you ever experienced thoughts of hurting yourself or others? Yes _____ or No _____
If yes, please explain _____

_____

Please circle any of the following problems that pertain to your current situation:

- **Nervousness**
- **Shyness**
- **Separation**
- **Self Control**
- **Drug Use/Alcohol**
- **Anger**
- **Sleep**
- **Legal Matters**
- **Trauma**
- **Loneliness**
- **In-Laws**
- **Children**
- **Depression**
- **Sexual Problems**
- **Stress**
- **Headaches**
- **Memory**
- **Insomnia**
- **Inferiority Feelings**
- **Career Choices**
- **Nightmares**
- **Appetite**
- **Being a Parent**
- **Health**
- **Marital/Relationship**
- **Digestion Problems**
- **Fears**
- **Suicidal Thoughts**
- **Finances**
- **Friends**
- **Unhappiness**
- **Work**
- **Fatigue**
- **Legal**
- **Making Decisions**
- **Concentration**
- **Eating Disorder**
- **Menopause**

STRESSORS (Self Assessment)

Place a check in the appropriate box for each of the stressors listed below to indicate how much stress you have been under during the past year. Be sure to check one of the boxes for each stressor listed. Use the 'NOT PRESENT' column if you have not experienced a specific type of stress during the past year.

List of Stressors	Not Present	Mild	Moderate	Severe	Extreme
Beginning/Ending Employment					
Job Problems					
Relocation					
Infertility					
Couple/Partner Issues					
Birth or Adoption of Child					
Separation/Divorce					
Death of a Loved One					
Physical Illness					
Financial Problems					
Caregiver Issues					
Conflict with Family Member					
Sexual problems or Infidelity					
School problems					
Legal Matters					
Addictions					
Retirement					
Starting a Business					
Adult Child Leaving Home					
Adult Child Living at Home					
OTHER					

Are you currently impacted from any past stressor or trauma that we should be aware of ? Yes or No
If yes, please explain. _____

_____

If yes, how does this past stressor or trauma currently impact your life? _____

_____

_____