GLEN F. PASTORES, LMFT #94162
1761 Hotel Circle South, Suite 380
San Diego, CA 92108
Phone: (858) 987-4848 Fax: (858) 987-4949

Patient / Client Name: _____Patient File #: _____

DOB:_____ Sex: ____ Martial status: _____Primary Care Physician: _____

Occupation: _____ Education: _____ Others living in the home: _____

Emergency Contact: _____ Phone #: _____

PRESENTING PROBLEMS - Please describe the reasons for seeking counseling (include date/month the problem started):

HISTORY OF PRESENT ILLNESS

Completed by Patient / Client

Please indicate how the following symptoms/problems/complaints are affecting you: (Leave blank if no affect)

1) Little 2) Some
3) Much 4) Significant

___ Eating habits / Appetite: eating more; eating less; weight change ____; binge; purge
___ Sleep: Trouble falling asleep; trouble staying asleep; trouble waking up
Average # hours sleep ___
Naps ___
___ Decrease energy/Fatigue
___ Sexual functioning
___ Loss of interest in activities
___ Tearfulness
___ Hopelessness / Helplessness
___ Decreased attention span
___ Inattentive / Distractible
___ Difficulty planning ahead
___ Opposition / Anger outbursts
___ Impulse control; difficulty controlling physical behavior or hyperactive
___ Mood changes
___ Anxious / Nervous
___ Worry / Fear
___ Stealing
___ Lying
___ Truancy
___ Fire setting

Start Time: _____ End Time: _____

CLINICAL PRESENTATION (Completed by Provider)

_____

_____

_____

_____

_____

_____

_____

TARGET SYMPTOMS (Completed by Provider)	**MEASURABLE GOALS** (Completed by Provider)
1.	
2.	
3.	
4.	

_____
Patient/Legal Rep. Signature Date

_____
Provider Signature/License # Date

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HISTORY OF PRESENT ILLNESS *continued*

Completed by Patients / Client	(Completed by Provider) **Target symptoms**	(Completed by Provider) **Measurable goals**
___ Police / Probation involvement	5. _____	_____
___ Spending sprees	_____	_____
___ Rapid Heartbeat		
___ Phobia	6. _____	_____
___ Sweating		
___ Trouble Breathing	_____	_____
___ Flashbacks of traumatic event	7. _____	_____
___ Nightmares	_____	_____
___ Racing thoughts		
___ Hearing voices		
___ Seeing things that are not there		

Substance Use

Completed by Patients / Client	(Completed by Provider) **Comments**	(Completed by Provider) **Goals and Interventions**
Coffee # ___ cups / day	Describe onset and duration; blackouts; withdrawal; attempts to stop; legal problems; DUI; work problems; relationship problems; hospitalizations; treatment	Recommendations: Does the patient/client need further evaluation? YES NO
Cigarettes # ____ per / day		Referral for CD Tx needed? Yes NO
Alcohol # ___ per / week		Relapse prevention; education
Date last drink: _____		
Street drugs:		
Type: _____	_____	_____
Amount: _____	_____	_____
Frequency: _____	_____	_____
Date last used: _____	_____	_____
Prescription Drugs	_____	_____
Type: _____	_____	_____
Amount: _____	_____	_____
Frequency: _____	_____	_____
Date last used: _____	_____	_____
Describe impact of substance abuse on your life: _____	_____	_____
_____	_____	_____
_____	_____	_____
Part treatment for substance use:	_____	_____
_____	_____	_____
_____	_____	_____
Family history of substance use:		
_____		

_____

Patient/Legal Rep. Signature Provider Signature / License # Date

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Psychosocial History / Functioning

Completed by Patient / Client

Rate how the problems/symptoms/ complaints are impacting area of **FUNCTIONING:**

1) Mild 2) Moderate 3) Severe

___ Marriage / Relationship
___ Work / School
___ Family
___ Friendships
___ Financial situation
___ Physical health
___ Social interests
___ Leisure activities
___ Clubs / Group memberships
___ Legal
___ Housing
___ Attending to daily living activities (i.e. shower, grooming, self care, etc.)
___ Spirituality
___ Current stressors

CLINICAL PRESENTATION & LEVEL OF FUNCTIONING

(Completed by Provider)

_____
_____
_____
_____
_____
_____
_____

TARGET SYMPTOMS (Completed by Provider)	**MEASURABLE GOALS** (Completed by Provider)
1.	
2.	
3.	
4.	

WHAT DO YOU SEE AS STRENGTHS:_____

WHAT DO YOU SEE AS WEAKNESSES:_____

GOALS FOR TREATMENT:_____

GOALS AND EXPECTATIONS OF SIGNIFICANT OTHERS:_____

_____

MOTIVATION FOR TREATMENT:_____

WHAT CULTURAL EXPERIENCES DO YOU FEEL WOULD BE HELPFUL IN YOUR TREATMENT:_____

_____

_____

Patient/Legal Rep. Signature Provider Signature / License # Date

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Patient / Client Name: _____ Patient File #: _____

Past Treatment History

Completed by Patient / Client

Psychiatric or psychological treatment of any kind before? YES ☐ NO ☐

If Yes, what type of care was received?
Inpatient ___ Outpatient ___ Both ___

When was the treatment? _____

Where was the treatment? _____

How long was the treatment? _____

Name(s) of therapist or doctor: _____

_____

Were medication prescribed at the time? YES ☐ NO ☐

If Yes, what was prescribed (include dosages if known)? _____

Family history of psychiatric treatment:

_____

Family members currently in psychiatric treatment:

_____

(Completed by Provider)

Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient / Legal Representative Must Complete the following Medical History

MEDICAL HISTORY: _____

ALLERGIES: _____

Current Medications: (Dosage, frequency, and prescribing M.D.) _____

_____

HISTORY OF INFECTIOUS DISESASES: (PANDAS, encephalitis, Lyme Disease, meningitis, GABHS)

☐None Reported _____

Are you currently taking any medication for PAIN MANGEMENT? ☐YES ☐NO

If YES, what medication? _____

Prescribing Pain Medication M.D. _____

Over the Counter Medications, Herbal Medicines, Supplements: _____

_____

FEMALE LIFE CYCLE HISTORY: Current # pregnancy? ___ Are you planning for pregnancy? ☐YES ☐NO

If YES, when? _____ When was your last menstrual period? _____

Are you currently using any form of birth control? If YES, what? _____

Other information the provider should know (i.e. family medical history): _____

_____

_____

Patient/Legal Rep. Signature Provider Signature / License # Date