GWEN SCHUBERT GRABB, LMFT
334 Tejon Place
Palos Verdes Estates, CA 90274

New Client Case History File/Intake

Client Name: _____ Date: _____
DOB: _____ Age: _____ SS#: _____
Address: _____
Home Phone: (_____) _____ Cell: (_____) _____ Work: (_____) _____
May we contact you at home? YES NO May we contact you on your cell? YES NO May we contact you at work? YES NO
E-mail: _____

Who referred you here _____
Relationship Status:_____ Length of time_____

Person financially responsible, if not yourself _____
Relation: _____ Phone: (_____) _____
If client is a minor, person responsible/guardian: _____
Relation: _____ Phone: (_____) _____
Name of School: _____ Grade Level: _____

Emergency Contact Info (if different from person above)
Name: _____
Relation: _____ Phone: (_____)
_____
Address: _____

Care Providers (relevant)

	Name	Phone #	Length of Treatment	Frequency of Visits	Most Recent Visit
Therapist					
Psychiatrist					
Physician					
Dietitian					
Other					

Current Medications *(including prescriptions, over-the-counter medicine, vitamins and herbal supplements)*

Medication	Dosage	Frequency	Began Taking	Prescribed By	Phone #

Please list any additional medication or relevant medical information:

How much has this problem affected the following areas

	No Affect	Little Affect	Some Affect	Much Affect	Significant Affect	Not Applicable
Marriage/ Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping habits	1	2	3	4	5	N/A
Sexual functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

Employment /Education Information

Highest grade level completed: _____ Field of study: _____

History of learning disability? [ ] Yes [ ] No If yes, explain: _____

Employment

Current Employment Status_____ Job Title _____

Level of satisfaction or comments_____

Social Support System

Activities you currently enjoy

_____

Use of other substances or behaviors – how much and how often

coffee:_____marajuana_____cigarettes_____Other_____

Why are you seeking treatment at this time?

I am aware that if I do not cancel 24 hours ahead of my appointment I will be charged full fee.

Client Signature _____ **Date**_____