Deonae Shackelflord, MSW, LCSW
Licensed Clinical Social Worker #121067
www.healinghouselosangeles.com
(818) 798-8086
Email: deonae@healinghouse.com

All information requested below is strictly confidential and cannot be released without your written permission.

Name:_____ Today's Date:_____

Street Address _____ City _____ Zip _____

Social Security #: _____ Date of Birth:_____

Contact Information

Please indicate each way you may be contacted. If an item does not apply write "N/A". **Please check the item that is the best most reliable way of contacting you**.

☐Home Phone ( ) _____ May a message be left: ☐ Yes ☐ No

☐Cell Phone: ( ) _____ May a message be left: ☐ Yes ☐ No
May a text message be left: ☐ Yes ☐ No

☐Work Phone ( ) _____ May a message be left: ☐ Yes ☐ No

E-Mail:_____

(This ***will not*** be given out or used as a primary method of contacting you)

Emergency Contact

Name _____ Phone ( ) _____

Address _____ Relationship _____

How did you hear about us:

☐ Self ☐ Family/Friend ☐ Counselor/Therapist ☐ Former Client

☐ Church ☐ School ☐ Physician/Psychiatrist ☐ Internet Search

☐ Court ☐ Attorney ☐ EAP ☐ Insurance Company

☐ Probation: P.O. Name _____ Phone: _____

☐ DCFS: CSW Name: _____ Phone: _____

☐ Other: Name:_____ Phone: _____

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Employment Information

Employer Name:_____ Phone ( )_____

May you be contacted at work: ☐ Yes ☐ No Length of current employment:_____

Job Title/Description of duties:_____

_____

Education:

Highest grade of school completed:_____ Year:_____

Degree Received:_____ Trade/Occupational training:_____

Mental Health Information: Reason(s) you are seeking therapy at this time?_____

_____

_____

Have you been in therapy before? ☐ No ☐ Yes - If yes, please indicate approximate dates, name of treatment provider, city and reason for treatment. *(Please note, your previous provider MAY NOT be contacted without your written approval)*_____

_____

Is there a history of mental illness in your family?	☐ No ☐ Yes
Have you ever been diagnosed with a mental disorder?	☐ No ☐ Yes
Have you ever been diagnosed with a mood disorder?	☐ No ☐ Yes
Does anyone in your family have issues with alcohol?	☐ No ☐ Yes
Does anyone in your family have prescription drug issues?	☐ No ☐ Yes
Does anyone in your family have other substance issues?	☐ No ☐ Yes

Medication Information: ☐ **None**

List all medications that are being prescribed to you by a physician/psychiatrist and the indication:

Medication Name	Reason Taken	MD/Psychiatrist	How Long

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Client Concerns Checklist

Please indicate all the reasons you are seeking therapy or that are effecting you. For each person below:

Your Name: _____

Child Name: _____

Partner Name: _____

Self	Child	Partner		Self	Child	Partner		Self	Child	Partner		Self	Child	Partner	
☐	☐	☐	Anxiety	☐	☐	☐	Nervousness	☐	☐	☐	Cheating	☐	☐	☐	Depression
☐	☐	☐	Fatigue	☐	☐	☐	Sadness	☐	☐	☐	Emptiness	☐	☐	☐	Poor concentration
☐	☐	☐	Grief	☐	☐	☐	Loneliness	☐	☐	☐	Indecision	☐	☐	☐	Poor self-care
☐	☐	☐	Guilt	☐	☐	☐	Failure	☐	☐	☐	DCFS Case	☐	☐	☐	Feeling isolated
☐	☐	☐	Anger	☐	☐	☐	Flashbacks	☐	☐	☐	Alcohol Abuse	☐	☐	☐	Inferiority feelings
☐	☐	☐	Fear(s)	☐	☐	☐	Withdrawn	☐	☐	☐	Nightmares	☐	☐	☐	Stress reaction
☐	☐	☐	Rape	☐	☐	☐	Outbursts	☐	☐	☐	Aggression	☐	☐	☐	Accident prone
☐	☐	☐	Robbery	☐	☐	☐	Assault	☐	☐	☐	Date rape	☐	☐	☐	Work performance
☐	☐	☐	Breakup	☐	☐	☐	Drug abuse	☐	☐	☐	Panic attacks	☐	☐	☐	Traumatic event
☐	☐	☐	Alcohol	☐	☐	☐	Poor grades	☐	☐	☐	Dishonesty	☐	☐	☐	Sleep disturbances
☐	☐	☐	Paranoid	☐	☐	☐	Violence	☐	☐	☐	Mood Swings	☐	☐	☐	Impulsiveness
☐	☐	☐	Shyness	☐	☐	☐	Insecurity	☐	☐	☐	Low energy	☐	☐	☐	Pulling out hair
☐	☐	☐	Rages	☐	☐	☐	Confusion	☐	☐	☐	Procrastination	☐	☐	☐	Skin picking
☐	☐	☐	Jealousy	☐	☐	☐	Inattention	☐	☐	☐	Overwhelmed	☐	☐	☐	Over spending
☐	☐	☐	Stealing	☐	☐	☐	Obesity	☐	☐	☐	Mixed feelings	☐	☐	☐	Drug use
☐	☐	☐	Phobias	☐	☐	☐	Cutting	☐	☐	☐	Hopelessness	☐	☐	☐	Unemployment
☐	☐	☐	Hostility	☐	☐	☐	Isolation	☐	☐	☐	Loss of control	☐	☐	☐	Lying
☐	☐	☐	Arguing	☐	☐	☐	Overeating	☐	☐	☐	Work stress	☐	☐	☐	Poor sex drive
☐	☐	☐	Tension	☐	☐	☐	Irritability	☐	☐	☐	Tiredness	☐	☐	☐	Fearful
☐	☐	☐	Ritualized or compulsive behaviors												
☐	☐	☐	Self-harm behaviors (cutting, burning, etc.)												
☐	☐	☐	Sexually acting out behaviors												
☐	☐	☐	Childhood sexual abuse												
☐	☐	☐	Sexual harassment at work or school												
☐	☐	☐	Interpersonal conflicts												
☐	☐	☐	Other:												

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What are some of your concerns/hesitations about participating in therapy? Check all that apply:

☐ I have no concerns/hesitations about therapy

☐ I don't see what the problem is

☐ I have a difficult time opening up

☐ I'm not the problem

☐ I'm being pressured to attend

☐ I don't feel that I need to change anything

☐ Being in therapy means you are crazy

☐ Therapy/counseling does not work

☐ I can take care of it myself

☐ Personal problems should be kept in the family

☐ Being in therapy means you are weak

☐ Feelings are not important

☐ Other people have worse problems than I do

☐ I worry people will find out I'm in therapy

☐ I don't want others to find out what I talk about

☐ I might get worse if I talk about my private thoughts

☐ It scares me to talk about my past

☐ I can't be helped

☐ I'm afraid I will get worse

☐ Other: _____

Please list specific days and times that are best for you for your sessions. Every effort will be made to accommodate your schedule: _____

_____