Lisa Blum, Psy.D.
Clinical Psychologist
CA LIC# PSY19790
323-633-6138

Full Name:____**Today's Date:** ___________

Date of Birth: _________________ **Age**: _______

Home Address: ____

____

School/Work Address: ____

____

Preferred mailing address? ☐Home ☐ School/Work ☐ Other:

Do you wish to receive a monthly statement for your records? ☐Yes ☐ Not necessary
May I send this statement to you as a pdf attachment in an email? ☐Yes ☐ No, prefer hard copy

E-mail address (please print clearly):____________________________☐ OK to use e-mail for communication

Phone: Home:_____________________________ Work: ____________________________

Cell:______________________________ Other:____________________________

Primary Care Physician and contact info: ____

Calls will be discrete, but in the event that I need to reach you, where is the best place for me to leave a message for you? Cell ☐ Home ☐ Work ☐

Personal Information:

Relational status: ___________________________ Gender: ______________ Ethnicity: _____________

Social Sec. #: ______________________________

Employed □ No □ Part- time □ Full-time Employer: ____

Student □ No □ Part- time □ Full-time School/College: _____________________________________

Names and ages of children:____

Who referred you to me? __________________________________ May I thank this person? ___________

Emergency Contact Information:

Name: Relationship:

Phone:

Date: _____________

Your responses to the following "yes/no" questions will serve as a springboard for further discussion when we meet. I have not asked for written details here because in most cases it is more useful for us to dialogue about these issues. Please note:

- **Your answers will be treated with confidence.**
- **Please respond only to those questions you feel comfortable answering.**

Thank you!

1. Have you ever worked with a counselor or therapist before? Yes / No
2. Have you ever been given one or more psychological tests? Yes / No
3. Have you ever been hospitalized for psychological or emotional problems? Yes / No
4. Are you currently taking any prescription medications? Yes / No

   If yes, what are they? ____

   Prescribed by whom? ____
5. Have you ever taken any medications for psychological difficulties? Yes / No
6. Have you ever attempted suicide? Yes / No
7. Have you ever been diagnosed with a serious medical illness? Yes / No
8. Do you have any medical conditions that may affect your mental health treatment? Yes / No

   If yes, please describe: ____
9. Do you have a visible or invisible disability? __________________________________Yes / No
10. Are you physically active? Yes / No
11. Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Yes / No
12. Have you ever been in a 12-step program? Yes / No
13. Do you drink alcohol? Yes / No

    If yes, please describe: ____
14. Do you currently use street drugs or controlled substances not prescribed for you? Yes / No
15. Who is your medical doctor? ____
16. When did you last meet with him/her? ____
17. Do you have any specific goals with regard to your therapy/counseling (please describe)?

    ____

    ____
18. Do you have any particular concerns/fears with regard to therapy/counseling?

    ____

    ____