Sedigheh "Dokie Riahi" Kashani, M.A., LMFT

850 Middlefield Rd., Suite 4
Palo Alto, CA 94301
Phone: 408-691-6528
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Greetings,

My first priority is to get to know you. While learning about you will be an ongoing process, our first meetings will be focused primarily on such information gathering. In order to utilize our time together during this phase more sufficiently, I request that you please take the time to legibly fill-out the form below and bring it with you to your first meeting. If any area of the form is unclear for you, please leave it blank and review it with me during your first appointment. Please note that if this form is not completed prior to your first meeting, you will be asked to complete it prior entering your meeting or during your appointment time. While you are welcomed to type your responses on the Word document directly and/or personally drop the form off during business hours prior to your appoint; **do not e-mail or mail this form, as once it is completed, it will contain information that needs to be treated confidentially.**

Please feel free to contact me with any questions or concerns at (408) 691-6528.

I look forward to meeting you.

Sincerely,

Dokie Riahi, LMFT

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Adult Intake

The information below must be provided by the client.

BACKGROUND INFORMATION

Full name _____ **Date** _____

Date of birth ____/_____/_____ **Age** _____ **Gender:** Male Female

Ethnicity _____

Language(s) spoken _____

Religion (if any) _____

Home Address _____
Name Street City Zip

Marital status (please check): ☐Single ☐In a relationship ☐Married
☐Separated ☐ Divorced ☐Cohabiting
☐ Widowed

Are you employed? Yes No
If yes, what do you do? _____

Do you attend school or any type of training? Yes No
If yes, what is the name of the institution?_____
What are you studying? _____

How many children have you conceived? _____
How many children do you have? _____
Have all of your children been from the same partner? Yes No
If no, please provide the information below:

Full name of child	Full name of child's biological mother	Full name of child's biological father	Child's age

1. Telephones: please provide the telephone number(s) where you can be reached. Feel free to use the blank boxes to provide alternative numbers.

Where	**Full name of contact person**	**Contact person's relationship to you**	**Number**	**Is it OK to leave you a message at this number?**
Home			( )	Yes No
Work			( )	Yes No
Cell			( )	Yes No
Emergency Contact			( )	Yes No
Alternative 1			( )	Yes No
Alternative 2			( )	Yes No

Note: Please be advised that if there is an emergency during my work with you child, where I have reasonable suspicion about you injuring yourself or others or where you are judged to need immediate psychiatric or medical care, I will take the necessary steps within the limits of the law, to keep you safe. Depending on the severity of the situation, these steps may include, but are not limited to, informing members of your support system, contacting an ambulance, or seeking the support of the police. Should such a situation present itself, I may have to contact the person(s) whose name you have provided on the "emergency" and "alternative" sections above.

2. Information about all who live with you including all children even if already named above.

Full name	**Relation to the you**	**Age**

MEDICAL INFORMATION

3. Previous Therapy (Check all that apply);

☐None ☐Individual ☐Couple ☐Family ☐Group ☐Inpatient

Name of Therapist _____ How long? _____For what? _____

Results? _____

☐None ☐Individual ☐Couple ☐Family ☐Group ☐Inpatient

Name of Therapist _____ How long? _____For what? _____

Results? _____

☐None ☐Individual ☐Couple ☐Family ☐Group ☐Inpatient

Name of Therapist _____ How long? _____For what? _____

Results? _____

4. Have you ever been hospitalized for mental or emotional problems? Yes No

If yes:

When were you hospitalized?	For how long were you hospitalized?	Why were hospitalized?

5. Please clearly list all regularly taken medication. Make sure to include prescribed as well as any over-the-counter medications (use the back of this paper or attach an additional sheet if needed).

Name of medication	**Dosage**	**How Often Is It Taken**	Please put a "P" for **Prescribed or** "OTC" for **Over-the-counter**	**Reason taken**	**Major Side Effects**

6. Medical history (please check all that apply to the you and describe below):

☐ Head injury/stroke	☐ Thyroid problems	☐ Chronic pain (incl. location) _____ _____	☐ Sexually Transmitted Disorder (STD)
☐ Loss of consciousness	☐ Cancer	☐ Trouble controlling urine or bowel	☐ Respiratory problems
☐ Kidney disease	☐ Diabetes	☐ Allergies	☐ Seizures
☐ Heart/vascular problems	☐ Sleep disturbances	☐ Adverse reaction to meds	☐ Recurrent pain (please indicate location) _____ _____ _____
☐ Hypertension/high	☐ Appetite changes	☐ Auditory problems	☐ Visual problems

blood pressure

☐ Liver disease ☐ Weight changes ☐ Pregnancy ☐ Other (please name) _____
_____

Please explain all marked items (**EXAMPLE**: if you checked "Respiratory Problem" write "have asthma but is under control with medication"):

_____
_____
_____
_____
_____

7. Has you had a physical examination within the past 6 months? Yes No

8. Are you under the care of a primary care physician? Yes No
If yes, what is the name _____ and phone numbers _____ of your doctor.

9. Please list all the substances that you use (ex: alcohol, stimulants, sedatives, hallucinogens, nicotine, caffeine, misuse of medication, huffing, etc.): If you use no substances write "none" under the Type column.

Type	Date of Last Use	Amount of Last Use	Frequency and Amount of Use	Length of Time Using	Age of First Use

Have you been involved with any recovery programs? Yes No

If yes, please complete below:

Name of program	Reason entered	Date entered program	Date ended program

RESOURCES

10. What are your strengths? For example, what are you good at? How would you describe your personality? What do you like to do?

_____
_____
_____
_____
_____

11. Where do you get your support from? Where or to whom do you reach out to when needing support? (ex: family church, friends, etc.)

_____
_____
_____
_____

STRESSORS

12. Stress factors: in life there are many stressors which impact us. Below are some common stressors that people face as well as some ways people respond to stress while trying to adjust to them. Please check all that apply to you. If you mark "yes" on any question, provide an explanation. Feel free to use additional paper or the back of the form if the explanation box is too small. However, keep in mind that you will have time to verbally elaborate on these matters during your first meeting.
Here is an **EXAMPLE** of how to answer the questions below:

Yes		If yes, please explain. Include dates when possible.
A) ☑	Have you ever hurt or threaten to hurt or kill others?	When mad I may say "I wish you were all dead" however, I have never physically hurt anyone or acted on these words.
D) ☑	Have you experienced trauma?	I was hit and touched in my genitals by my step-father from the age of 3 years to 6 years. I was slapped, hit with a belt, and pushed. As a result I got bruises and was removed from my parents house by CPS when I was 6 years old.

E) ☑	Has you experienced Neglect or Abuse?	See explanation for question D.

Now it's your turn.

Yes		If yes, please explain. Include dates when possible.
A) ☐	Have you ever hurt or threaten to hurt or kill others?	
B) ☐	Have you ever tried to kill or harm yourself (ex: cutting, suicide attempts, etc.)? Do you ever wish you were dead?	
C) ☐	Do you have access to weapons?	
D) ☐	Have you experienced trauma?	
E) ☐	Have you experienced Neglect or Abuse?	
F) ☐	Have you experienced domestic violence?	
G) ☐	Are you involved with any legal issues (ex: custody issues, criminal charges, etc.)?	
H) ☐	Do you have or have you had crime/gang involvement?	
I) ☐	Do you engage in any risky sexual behavior (ex: unprotected sex with multiple partners)?	
J) ☐	Are you or have you abused any drugs and/or alcohol?	
K)	Do you experience cultural isolation	

☐	(ex: discrimination, rejection, isolation, etc.)?	
L) ☐	Are you at risk of homelessness?	
M) ☐	Are you frequently sad or tearful?	
N) ☐	Have you lost interest in activities that you use to enjoy in the past (ex: hobbies, sex, time with friends, etc.).	
O) ☐	Are you frequently fearful? Do you have many worries? Are you often too anxious to take risks?	
P) ☐	Do others describe you as withdrawn?	
Q) ☐	Do you have problem at bedtime (ex: difficulty falling asleep or walking-up, nightmares, sleepwalking, etc.)?	
R) ☐	Do you have eating problems (being overweight or underweight)? Do you have excessively negative feelings about your body?	
S) ☐	Do you fear or avoid certain people or places?	
T) ☐	Do you have temper outbursts? Do you excessively yells, fights, or hit?	
U) ☐	Do you destroy property/things?	
V) ☐	Do you lie or steal?	
W)	Do you set fires?	

☐		
X) ☐	Do you experience frequent physical complaints (ex: headaches, stomachaches, etc.)?	
Y) ☐	Have you experienced a recent separation/divorce?	
Z) ☐	Have you experienced a recent move?	
A2) ☐	Has there been a new s addition to your family either through birth, adoption, blending of families, etc?	
B2) ☐	Is anyone in the family experiencing chronic illness?	
C2) ☐	Is anyone in the family dealing with mental illness?	
D2) ☐	Has there been a recent death in the family?	
E2) ☐	Is your family experiencing any financial problems?	
F2) ☐	Have you experienced any recent changes in school, work, relocation, etc?	
G2) ☐	Are you overly active?	
H2)	Do you have difficulty with	

☐	attention and/or concentration?	
I2) ☐	Do you have frequent conflict with others?	
J2) ☐	Do you have any friends?	
K2) ☐	Do you have any learning difficulties?	

CURRENT CONCERNS AND GOALS

13. List your reason(s) for seeking counseling at this time.

(1) _____
(2) _____
(3) _____
(4) _____

SIGNATURE

Full name of the person filling-out this form _____

Signature of the person filling-out this form _____

If anyone helped you fill this form (by offering translation, etc.) please complete the following:

What is the full name of the person who helped you? _____

What relation does this person have to the youth? _____

Is this person 18 year old or older? Yes No

If no, how old is this person? _____