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Client Information

1. What are your current symptoms (issues) that you are experiencing?

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2. How long have the symptoms (issues) been occurring?

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3. Have there been any major changes at work or at home? Yes No If yes, please explain below

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4. Are you currently receiving any therapy/medical treatment? Yes No If yes please answer below

Where is the current place of treatment? \_\_\_\_\_

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5. Have you received any previous therapeutic/psychological treatment? Yes No If yes please answer below

What were the reason(s) for the treatment? \_\_\_\_\_

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6. Have you ever been prescribed or currently on any psychotropic medication? Yes No If yes please explain below

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7. Are you experiencing any thoughts of self-harm? Yes No

8. Harm to others?    Yes    No

9. Are you exhibiting any of the following symptoms?

Fatigue	Yes	No	Hearing Voices	Yes	No	Sexual Acting Out	Yes	No
Lying	Yes	No	Bed Wetting	Yes	No	Stomach Problems	Yes	No
Worries	Yes	No	Poor Appetite	Yes	No	Difficulty Sleeping	Yes	No
Anxiety	Yes	No	Change in Mood	Yes	No	Poor Concentration	Yes	No
Hyperactivity	Yes	No	“Sleep Walking”	Yes	No	Bowel Problems	Yes	No
Stealing	Yes	No	Unusual Fears	Yes	No	Nightmares/Bad Dreams	Yes	No
Frequent Anger Outbursts	Yes	No						

If you answered yes to any of the previous questions please give more details in the space below.

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10. Please list below any other concerns you have?

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11. What would you like to get out of coming to therapy?

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Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date