NARDINE AZAB, M.S, MFT

www.nardineazab.com

PERSONAL INFORMATION

Client Name: _____ Date of Birth: _____

Address: _____

Home Phone:_____ Cell Phone: _____Work Phone:_____

Ok to leave msg __yes ___no Ok to leave msg __yes ___no Ok to leave msg __yes ___no

Emergency Contact: _____

Marital Status: Single / Married / Divorced / Separated / Widowed / Partnered

Occupation/Employer: _____

Highest Level of Education Completed: _____

Living Situation: Alone / Spouse / Roommate(s) / Children

Name, Age, and relationship of others in the home:

_____

_____

_____

FAMILY HISTORY

(Please circle any that apply and indicate relationship)

Anxiety/Depression
Bipolar Disorder
ADHD
Obsessive Compulsive Disorder
Trauma/Abuse
Alcohol/Drug Problem
Gambling Problem
Eating Disorder
Schizophrenia
Suicide attempt/Completion

SUBSTANCE USE

	Present	Past
Tobacco	_____	_____
Alcohol	_____	_____
Marijuana	_____	_____
Opioids / Pain killer	_____	_____
Benzodiazepines	_____	_____
Amphetamines / Cocaine	_____	_____
Hallucinogens	_____	_____
Other drugs	_____	_____

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MEDICATIONS (Prescribed & over the counter)	Dosage/Frequency	Date 1st Prescribed
_____	_____	_____
_____	_____	_____
_____	_____	_____

SYMPTOMS

In the past 6 months have you experienced significant symptoms of (Please circle)

Irritability	Guilt	Low Motivation
Anxiety/Fears	Hopelessness	Guilt
Sadness	Excessive Worry	Hopelessness
Crying Spells	Panic	Self-Harm Behaviors
Insomnia/Hypersomnia	Nightmares	Disordered Eating Patterns
Poor Focus	Flashbacks	Somatic Complaints
Emotional Numbing	Distressing Memories	Recent Losses
Low Motivation	Hypervigilance	Recent Life Changes

Please describe why you're seeking therapy at this time:

Goals for therapy and what you hope to achieve:

Signed: _____ Date: _____