

CONFIDENTIAL

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Please fill out this form and bring it to your first session. All of the information you provide is confidential and will not be disclosed without your written permission.

Name: _____

Name of parent/guardian (if under 18 years of age): _____

Date of Birth: _____

Address: _____

Home phone: _____ **May I leave a message?** _____

Cell phone: _____ **May I leave a message?** _____

Email address: _____ **May I email you about routine issues?** _____

Who referred you: _____

Insurance carrier: _____

Name of insured: _____

Mental Health Insurer if different from above: _____

Member ID #: _____ **Group #:** _____

Mental Health Insurance phone # (on back of card): _____

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Marital Status: _____

Please list any children you have and their ages: _____

Are you currently employed? _____ **Who is your employer?** _____

Please describe your current work situation (Are you satisfied with your work? Is your work stressful? Do you have conflict with co-workers or boss?):

MENTAL HEALTH AND GENERAL HEALTH INFORMATION

List any specific health conditions you are currently experiencing: _____

Are you currently experiencing chronic pain? If so please describe: _____

Please list any specific sleep problems you are experiencing: _____

Please list any specific difficulties you are having with eating or appetite: _____

Please list any prescription drugs you are currently taking: _____

Do you drink alcohol more than once per week? _____ **How much?** _____

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Are you currently in a romantic relationship and if so for how long? _____

Are you currently experiencing overwhelming sadness, grief or depression? _____

Are you currently experiencing anxiety, panic attacks or phobias? _____

Have you experienced suicidal thoughts in the past week? _____

Have you ever attempted suicide and if so when and how? _____

Have you ever been hospitalized for depression, manic episode, anxiety or other mental health condition and if so when?

FAMILY MENTAL HEALTH HISTORY

Please circle any of the following problems that may have occurred in your family or extended family. Please list the family member's relationship to you (grandmother, father, uncle, cousin):

Alcohol/Substance abuse _____

Anxiety/ phobias _____

Depression _____

Domestic Violence _____

Eating Disorder _____

Obsessive Compulsive Behavior _____

Schizophrenia _____

Suicide _____

What would you like to accomplish as a result of your time in therapy? _____
