ELANAH D. NAFTALI, DrPH, LMFT, SEP
www.FeelingEase.com

143 West Walnut Lane, Ste. 203
Philadelphia, PA 19144

Phone: 215.498.6063
elanah.naftali@gmail.com

CLIENT INFORMATION

PATIENT NAME ________________________ **DATE** ____________

DATE OF BIRTH__________ **AGE** __________ **MARRIED?** ______ **#CHILDREN** __________

Home ADDRESS ____

CELL#________________ **Other#:** ______________ **Email** ________________

EMPLOYER /JOB TITLE ____________________ **OCCUPATION** __________________

Do you consider yourself spiritual or religious? ______________________

What gives your life meaning? ______________________

Do you have beliefs that help you cope with stress? ______________________

What are your self-care practices for dealing with stress? ______________________

____

Are you part of a spiritual or religious community? ______________________

Is there a group of people you really love or who are important to you? ______________

How do you take care of your body? ______________________

Do you get restful sleep? How often? ______________________

Do you have a special diet? Allergies? ______________________

Are you in chronic pain (where /type)? ______________________

How often do you drink alcohol? ______________________

How often do you use recreational drugs like cannabis? ______________________

Are you satisfied with your sex life? ______________________

Any sexual concerns you would like to discuss? ______________________

____

REASONS FOR SEEKING PROFESSIONAL HELP & WHAT YOU WOULD LIKE TO GET FROM THERAPY?

____

____

WHAT GOAL(S) WOULD YOU LIKE TO WORK ON?

____

____

ELANAH D. NAFTALI, DrPH, LMFT, SEP

www.FeelingEase.com

143 West Walnut Lane, Ste. 203
Philadelphia, PA 19144

Phone: 215.498.6063
elanah.naftali@gmail.com

Mental Health History / Treatment (Tx): Please include hospitalizations.

Type of Episode / Provider Name	Approx. Years of Tx	Any Ongoing Tx (medications /dosage)

Health History / Hospitalizations (Include chronic conditions & routine concerns):

Chronic Condition / Pain	Provider / Type of Tx	Current Medications

Family History of Emotional and/or Drug & Alcohol Related Problems:

Family Member	Mental Health Condition	Substance Use

Symptom Checklist (Circle all that Apply):

Depression	Low Energy /Fatigue	Irritability	Dizzy /Lightheaded
Hopelessness	Difficulty Sleeping	Obsessive Thinking	Sadness
Helplessness	Anger /Hostility	Panic Attacks	Chest Pain
Distorted Body Image	Low Self-Esteem	Fearfulness	Feeling of Choking
Tearfulness	Anxiety	Sexual Difficulties	Shortness of Breath
Mood Swings	Difficulty Concentrating	ReDuced Arousal/Desire	Disassociation
Self-Harm	Fear of Dying	Binging /Purging	Other_______________

Anything else you'd like me to know ____

____