ELANAH D. NAFTALI, DRPH, LMFT, SEP

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CLIENT INFORMATION

**PATIENT NAME (Nickname?):**  **DATE:**

**DATE OF BIRTH:**  **AGE: MARRIED (#Yrs?):**  **CHILDREN (Ages?):**

**Home Address:**

**CELL#:**  **Email: Other Contact:**

**EDUCATION /VOCATIONAL TRAINING:**

**Current Occupation:**

**Preferred Occupation (if different):**

**What gives your life meaning?**

**How do you cope with stress?**

**What are your daily practices for overall well being?**

**Are you connected to people in your life?**

**Do you belong to any in-person communities?**

**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)? Psychedelics?**

**Are you satisfied with your sex life?**

**Any sexual or gender identity issues to explore?**

**Are you more sensitive to external triggers (like temperature & noise) or internal triggers (like hunger & thirst)?**

**Which triggers cause you great distress or anxiety? What do you do about it?**

**What are your goals for therapy?**

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**MENTAL HEALTH HISTORY / TREATMENT ( INCLUDE HOSPITALIZATIONS):**

|  |  |  |
| --- | --- | --- |
| **TYPE OF EPISODE /** **PROVIDER NAME** | **APPROX. YEARS OF Treatment** | **ONGOING Treatments** **(MEDICATIONS /DOSAGE)** |
|  |  |  |
|  |  |  |
|  |  |  |

***Continue on next page as needed.***

**HEALTH HISTORY / HOSPITALIZATIONS (INCLUDE CHRONIC CONDITIONS & OTHER CONCERNS):**

| **CHRONIC CONDITION / PAIN OTHER HEALTH CONCERNS** | **PROVIDER / TYPE OF TX**  | **CURRENT MEDICATIONS** |
| --- | --- | --- |
|  |  |  |
|  |  |  |

***Continue on next page as needed.***

 **FAMILY HISTORY OF EMOTIONAL AND/OR DRUG & ALCOHOL RELATED PROBLEMS:**

|  |  |  |
| --- | --- | --- |
| **FAMILY MEMBER**  | **MENTAL HEALTH CONDITION**  | **SUBSTANCE USE** |
|  |  |  |
|  |  |  |

***Continue on next page as needed.***

**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 Dissociation · Self-harm · Fear of dying · Binging/purging · Other (fill in):**

**Do you have experience with hypnosis? Anything else you want me to know?**