JACQUE SIERAD, L.C.S.W.

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Westlake Village, CA 91361
(818) 224-2248
License # LCS 23008

Client Name:_____
Age:_____Date of Birth:_____Marital Status:_____
Address:_____
City,State,Zip:_____
Home Phone:_____Cell Phone:_____
Place of Business:_____Business Phone:_____
Name and Ages of Children:_____
Name of Person to Contact in Case of Emergency:_____
Phone:_____Relationship:_____
Serious Illnesses, Accidents, Operations,Medical Conditions:_____
_____
What Brings you Here At This Time:_____
_____
Previous Therapy Experiences: _____No _____Yes
Therapist _____Amount of Time:_____
Psychiatric Hospitalizations _____No _____Yes
Hospital:_____Amount of Time:_____
Family or Significant Other(s) Psychiatric Hospitalization: _____No _____Yes
Hospital:_____ Amount of Time_____
Use of Alcohol: _____No _____Yes
(if yes) Times Per: _____Day _____Week Type:_____Amount:_____
Use of Drugs: _____No _____Yes
(if yes) Times Per: _____Day _____Week Type:_____ Amount:_____
Eating Disorder: _____No _____Yes
(if yes) Type_____For How Long_____
History of Sexual Abuse _____No _____Yes
_____sexual intrusion _____molestation _____rape _____sexual harassment _____other_____
Physical Abuse: _____No _____Yes
(if yes) Type_____For How Long _____
Gambling, Shopping, other Addictions: _____No _____Yes
(if yes) Type_____For How Long _____
Suicidal History: _____ No _____Yes
(if yes) Explain_____
Additional Information:_____
_____

*Referred By:*_____
*Signature of Client:*_____*Date:*_____
*Signature of Parent:*_____*Date:*_____
(if client is a minor)