IAS COUNSELING SERVICES
Deborah Wieland, M.S. LMFT # 96864 714-717-1279
17111 Beach Blvd, Ste 203 Huntington Beach CA 92647

New Patient Information

Name:_____ Today's Date:_____

Date of Birth:_____ Age: _____ Sex: M ☐ F ☐ SS#:_____

Address:_____

City:_____ Zip:_____

Cell:_____ Work:_____ Home:_____

Marital Status:_____ Spouse's Name:_____

Children's Names/Ages:_____

Employer:_____ Occupation:_____

Presenting Issue/Reason Seeking Therapy:_____

_____

Referred By:_____ Primary Care Physician:_____

Phone:_____ Date last seen:_____

Current Medication and taken for:_____

_____

Current & Past Medical Conditions, Surgeries:_____

Emergency Contact:_____ Phone:_____

Assessment of Life Functioning

Please select how your emotional status or issues have affected the following areas (Circle Choice Below).

	No Effect	Low Effect	Some Effect	Much Effect	High Effect	N/A
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety/Nerves/Worry	1	2	3	4	5	N/A
Depressed Mood	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
Sleeping Habits	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to control Anger	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

Any Family History of Psychological or Psychiatric Conditions:_____

_____

Personal History of Psychological or Psychiatric Conditions

Have your or are you currently receiving psychiatric or psychological treatment? Yes ☐ No ☐

If yes, answer the following questions: What type of cared did you receive? Outpatient ☐ Inpatient ☐ Both ☐

What dates where you in treatment:_____

Who was treating you (provider name):_____

Please describe what you liked or disliked about your treatment:_____

_____

Were you prescribed any medication Yes ☐ No ☐ If yes, what were you prescribed:_____

_____

Habits: Coffee (X per day)_____ Cigarettes/Vape (Packs/day):_____

Other Habits: (Video gaming, computer, porn, etc):_____

_____

Past and Current Substance Use

When was the last time you drank any alcohol? _____

Please list the types of alcohol you drink and the frequency consumed:

Type (beer, vodka, wine, etc.)	Frequency	Amount

When was the last time you used any recreational drugs (marijuana, cocaine, speed, meth, heroin, ecstasy, etc)?

_____

Please list the types of drug/s you use and the frequency consumed:

Type	Frequency	Amount

Have you ever received any type of treatment for substance abuse? Yes ☐ No ☐ If yes, please answer the following: What type of treatment did you receive? Circle all that apply:

Inpatient ☐ Intensive Outpatient (IOP) ☐ Outpatient ☐ Support Groups (AA, NA) ☐

What dates where you in treatment? _____

Have you had any periods of sobriety? Yes ☐ No ☐ Dates of Sobriety:_____

Legal History

Are you involved in any legal proceedings? Yes ☐ No ☐ Comments:_____

Have you ever been arrested? Yes ☐ No ☐ Convicted of a crime? Yes ☐ No ☐

Comments:_____

Anything significant that you would like to add? _____

_____

CREDIT CARD AUTHORIZATION:

I, _____ authorize IAS Counseling Services to charge my credit card for retainer purposes and any unpaid balances and fees associated with counseling services provided by Deborah Wieland.

Any fees that are not paid at time of services are rendered will automatically be charged to my credit card. A receipt of the charge made will be:

☐ Emailed to:_____

☐ Mailed to me to the address below

_____ _____
Name as it appears on card Driver's License Number

_____ _____
Card Number Type of Card

_____ _____
3 or 4 Digit Code (on front or back of card) Expiration Date

_____
Billing Street Address for Credit Card Statement

_____ _____
City, State, Zip Phone

_____ _____
Printed Name Date

_____
Signature

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