Reach Your Goal Now with Dr. Cio Hernandez

Rocio Hernandez, MFT•Hernandez Family Counseling DBA Reach Your Goal Now
Private Practice and Consultation Services, Doctorate in Health Care Leadership, CA Lic.# MFC38444, LPC419, HI MFT 537
cio@reachyourgoalnow.com (510) 291-4603 (833) GOAL NOW

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. If anything is too difficult to answer, leave it blank and we will do it together.

Please fill out this form and bring it to your first session or email it to aza@azafrias.com

Legal first, middle and last names:

Chosen/preferred name, what would you like me to call you?:

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

Birth Date: _____ Age: _____
Day/Month/Year

Gender: ☐Man ☐Woman ☐Nonbinary ☐Other: _____

Marital Status:
☐Never married ☐Domestic partnership ☐Divorced ☐Married ☐Separated
☐Widowed

Please list the names and ages of all children	Names	Ages

Physical address:

Mailing address: *if different than above*	
Home Phone:	May we leave a message? ☐ Yes ☐ No
Cell/Other Phone:	May we leave a message? ☐ Yes ☐ No
E-mail:	May we email you? ☐ Yes ☐ No
Preferred communication?	☐ Home ☐ Cell ☐ Email ☐ Text message
*Please note: Email, text, and even secure video conferencing is not considered to be a confidential medium of communication	
Emergency Contact (name and phone number):	
How did you hear about us?	
Have you previously received any type of mental health services, (psychotherapy or psychiatric)?	☐ Yes ☐ No If yes, name of previous therapist/practitioner:
Are you currently taking any prescription medication?	☐ Yes ☐ No Please list:
Have you ever been prescribed psychiatric medication?	☐ Yes ☐ No Please list and provide dates:

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (check one)	☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
Please list any specific health problems you are currently experiencing:	
2. How would you rate your current sleeping habits? (check one)	☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good
Please select any specific sleep problems you are currently experiencing:	☐ Falling Asleep ☐ Staying asleep ☐ Waking up early and cannot go back to sleep ☐ Too much sleep, but still tired.
3. How many times per day you generally exercise? And What types?	
4. Please list any difficulties you experience with your appetite or eating patterns.	

5. Are you currently experiencing overwhelming sadness, grief or depression?	☐ Yes ☐ No If yes, how long?
6. Are you currently experiencing anxiety, panic attacks or have any phobias?	☐ Yes ☐ No If yes, when did you begin experiencing this?
7. Are you currently experiencing any chronic pain?	☐ Yes ☐ No If yes, please describe:
8. How many times do you drink alcohol per: day ____ week ____ month ____? I don't drink ☐	
9. Do you engage in recreational drug use? Which ones (select all that apply)? Please indicate if you use them: daily, weekly, monthly, infrequently, or never.	☐ Caffeine How often: ____ ☐ Marijuana How often: ____ ☐ Methamphetamine How often: ____ ☐ Cocaine How often: ____ ☐ Heroine How often: ____ ☐ Inhalants How often: ____

	☐ Over the Counter or Prescription Drugs Please List: How often:
10. Are you currently in a romantic relationship?	☐ Yes ☐ No If yes, for how long? On a scale of 1-10, how would you rate your relationship?
11. Do you have vision problems? ☐ Yes ☐ No Epilepsy? ☐ Yes ☐ No Eye tracking problems? ☐ Yes ☐ No	
12. What significant life changes or stressful events have you experienced recently?	

ADVERSE CHILDHOOD EXPERIENCES:

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

   ☐ No ☐ Yes; If Yes, enter 1:

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   ☐ No ☐ Yes; If Yes, enter 1:

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

☐ No ☐ Yes; If Yes, enter 1: ☐

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

☐ No ☐ Yes; If Yes, enter 1: ☐

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

☐ No ☐ Yes; If Yes, enter 1: ☐

6. Were your parents ever separated or divorced?

☐ No ☐ Yes; If Yes, enter 1: ☐

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

☐ No ☐ Yes; If Yes, enter 1: ☐

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

☐ No ☐ Yes; If Yes, enter 1: ☐

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

☐ No ☐ Yes; If Yes, enter 1: ☐

10. Did a household member go to prison?

☐ No ☐ Yes; If Yes, enter 1: ☐

Now add up your "Yes" answers: ☐ This is your ACE Score.

ADDITIONAL INFORMATION:

1. Are you currently employed?	☐ Yes ☐ No If yes, what is your current employment situation?

Do you enjoy your work?	☐ Yes ☐ No What is stressful about your current work? What do you enjoy?
2. Do you consider yourself to be spiritual or religious?	☐ Yes ☐ No Do you attend church services? ☐ Yes ☐ No If yes, describe your faith or belief:
3. What do you consider to be some of your strengths:	