Maya Heffernan, LMFT

Client Intake Form

Maya Heffernan, MA
Licensed Marriage and Family Therapist 111639
3990 Old Town Avenue, Suite B100, San Diego CA 92110
Phone: 619-277-1930

Personal Information		
Name:	Age:	DOB:
Address:		
Home Phone:	OK to leave message? ☐ Yes ☐ No	
Cell Phone:	OK to leave message? ☐ Yes ☐ No	
Email:	OK to email you? ☐ Yes ☐ No	
Please note: email and text correspondence is not considered to be a confidential medium of communication		
My therapist may identify him/herself when calling ☐ Yes ☐ No		
Marital Status:	Do you have children? ☐ Yes ☐ No	Age(s) of children:
Occupation:		
How did you hear about Maya Heffernan LMFT? ☐ Web search ☐ Friend ☐ Church ☐ Former Client ☐ Other		
Name of referral:	May I thank this person? ☐ Yes ☐ No	

Emergency Contact Information	
Name:	Phone:
Relationship to client:	

Health and Medical History	
List any major illnesses:	
List medications you are currently taking and purpose of each:	
Are you currently under the care of a psychiatrist? ☐ Yes ☐ No	
	If yes, what are you being treated for?
Have you used illegal or non-prescribed drugs in the last year? ☐ Yes ☐ No	
	If yes, what drugs/substances?
	If yes, how often do you use them?
Do you drink alcohol? ☐ Yes ☐ No	How often do you drink? / How much?
Have you ever received treatment for an eating disorder or for substance abuse? ☐ Yes ☐ No	
	If yes, what type of treatment (NA, AA, HA, Inpatient, Outpatient)?

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Have you ***ever*** had thoughts of ending your life in the past? ☐ Yes ☐ No

If yes, when were the thoughts?

What method would you have used?

Have you had any of these thoughts in the last **6 months**? ☐ Yes ☐ No

Have you ever attempted to take or end your life? ☐ Yes ☐ No

If yes, when:

What method did you use?

Have you ever been hospitalized for a mental health issue? ☐ Yes ☐ No	If YES, when?

Personal & Family History

Have you ever experienced difficulties with any of the following?

Depression ☐ Yes ☐ No	Bipolar Disorder ☐ Yes ☐ No	Anxiety Disorder ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No	Alcohol/Substance Abuse ☐ Yes ☐ No	Eating Disorders ☐ Yes ☐ No
Trauma History ☐ Yes ☐ No	Suicide Attempts ☐ Yes ☐ No	Domestic Violence ☐ Yes ☐ No
Panic Attacks ☐ Yes ☐ No	Learning Disabilities ☐ Yes ☐ No	Other:

If you answered 'yes' to any above, please explain *(when, symptoms, severity, treatment received):*

Has anyone in your family experienced any of the above? ☐ Yes ☐ No
If 'yes' please explain *(which family member, when, symptoms, severity, treatment received):*

How many people were in your family growing up?

Did you experience or witness abuse in your family? ☐ Yes ☐ No If yes: ☐ Physical ☐ Verbal ☐ Emotional ☐ Sexual

If 'yes' please explain:

Please describe why you are seeking counseling at this time:	

Client Signature _____ Date _____