



**Tiffany C. Shanks, MA, LMFT**  
Licensed Marriage & Family Therapist #84490  
(818) 493-9580  
tiffanyshankstherapy@gmail.com

21241 Ventura Blvd, Suite 182  
Woodland Hills, CA 91364

18075 Ventura Blvd, Suite 132  
Encino, CA 91316

### **Employment Information**

Employer Name: \_\_\_\_\_ Phone (     ) \_\_\_\_\_

May you be contacted at work:  Yes  No     Length of current employment: \_\_\_\_\_

Job Title/Description of duties: \_\_\_\_\_

### **Education:**

Highest grade of school completed: \_\_\_\_\_ Year: \_\_\_\_\_

Degree Received: \_\_\_\_\_ Trade/Occupational training: \_\_\_\_\_

**Mental Health Information:** Reason(s) you are seeking therapy at this time? \_\_\_\_\_

Have you been in therapy before?  No  Yes - If yes, please indicate approximate dates, name of treatment provider, city and reason for treatment. *(Please note, your previous provider MAY NOT be contacted without your written approval)* \_\_\_\_\_

Is there a history of mental illness in your family?  No  Yes  
Have you ever been diagnosed with a mental disorder?  No  Yes  
Have you ever been diagnosed with a mood disorder?  No  Yes  
Does anyone in your family have issues with alcohol?  No  Yes  
Does anyone in your family have prescription drug issues?  No  Yes  
Does anyone in your family have other substance issues?  No  Yes

### **Medication Information:** None

List all medications that are being prescribed to you by a physician/psychiatrist and the indication:

<u>Medication Name</u>	<u>Reason Taken</u>	<u>MD/Psychiatrist</u>	<u>How Long</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Client Concerns Checklist

Please indicate all the reasons you are seeking therapy or that are effecting you. For each person below:

Your Name: \_\_\_\_\_

Child Name: \_\_\_\_\_

Partner Name: \_\_\_\_\_

Self	Child	Partner		Self	Child	Partner		Self	Child	Partner		Self	Child	Partner	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emptiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indecision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor self-care
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DCFS Case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling isolated
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashbacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inferiority feelings
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fear(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress reaction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accident prone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Robbery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date rape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work performance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breakup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Traumatic event
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor grades	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dishonesty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbances
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsiveness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shyness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insecurity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulling out hair
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Procrastination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin picking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jealousy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Over spending
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mixed feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug use
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cutting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arguing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor sex drive
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fearful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ritualized or compulsive behaviors												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-harm behaviors (cutting, burning, etc.)												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually acting out behaviors												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Childhood sexual abuse												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual harassment at work or school												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interpersonal conflicts												
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:												

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**What are some of your concerns/hesitations about participating in therapy? Check all that apply:**

- I have no concerns/hesitations about therapy
- I don't see what the problem is
- I have a difficult time opening up
- I'm not the problem
- I'm being pressured to attend
- I don't feel that I need to change anything
- Being in therapy means you are crazy
- Therapy/counseling does not work
- I can take care of it myself
- Personal problems should be kept in the family
- Being in therapy means you are weak
- Feelings are not important
- Other people have worse problems than I do
- I worry people will find out I'm in therapy
- I don't want others to find out what I talk about
- I might get worse if I talk about my private thoughts
- It scares me to talk about my past
- I can't be helped
- I'm afraid I will get worse
- Other: \_\_\_\_\_

Please list specific days and times that are best for you for your sessions. Every effort will be made to accommodate your schedule: \_\_\_\_\_