Antonia Noble Ludwig Psy.D. MFT

5655 Lindero Canyon Rd #225, Westlake Village CA 91362 805 231 8162 www.westlakepsychotherapy.com

Individual Information

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name: ..... Date: .....

Parent / Legal Guardian (if under 18): .....

Address: .....

.....

Home Phone: ..... May we leave a message? ☐ Yes ☐ No

Cell Phone: ..... May we leave a message? ☐ Yes ☐ No

Email: ..... May we leave a message? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Birth Date: ..... Age: ..... Gender: .....

Martial Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Referred By (if any): .....

Person to contact in an emergency: .....

Contact's Address and Phone: .....

.....

Insurance Information

Insured person: ..... Relationship: .....

Soc. Sec. No. : ..... Birth Date: .....

Insurance Co. : ..... Insured ID# : .....

Policy / Group # : ..... Insurance Co. Phone : .....

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History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes, previous therapist/practitioner:

Are you currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list and dosage:

Have you ever been prescribed psychiatric medication: ☐ Yes ☐ No

If yes, please list and provide dates:

General and Mental Health Information

1. How would you rate your current physical health? ☐ 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? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing:

3. How many times per week do you generally exercise?

What types of exercise do you participate in?

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History (cont.)

4. Please list any difficulties you experience with your appetite or eating problems:

5. Are you currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long?

6. Are you currently experiencing anxiety, panics 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. Do you drink alcohol more than once a week? ☐ Yes ☐ No

If yes, please describe:

9. Do you engage in recreational drug use? ☐ Yes ☐ No

If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

10. Are you currently in a romantic relationship? ☐ Yes ☐ No If yes, for how long?

What do you like about your relationship?

Is there anything you would change?

11. What significant life changes or stressful events have you experienced recently?

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Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Condition		Family Member
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	

Additional Information

1. Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

Do you enjoy your work? Is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? ☐ Yes ☐ No

If yes, describe your faith or belief:

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Additional Information (cont.)

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

In signing this agreement my signature acknowledges that I fully agree to and accept the following conditions:

I authorize the release of medical or treatment information necessary to process my insurance claim including the release of a mental or chemical dependency diagnosis.

I understand (if I request) I will be given a super bill at the end of the month to submit to my insurance company. I accept full responsibility for payment and it is my responsibility to collect reimbursement from my insurance carrier. I understand and accept all financial responsibility for treatment.

Client Signature Date