Client: Tolunay Kaya
DOB: 12/14/1995
Provider: Leslie Medrano

roamers therapy

Initial Assessments

Race:

White

Ethnicity:

Turkish

Gender Identity:

Male

Do you identify with a specific religion/spirituality?

No

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can

Past family trauma

What are your goals for counseling?

To beat the past trauma

Are you seeking psychotherapy to be provided with documentation, this includes, but not limited to: ESA letters, FMLA, Short Term Disability, legal/ court involvement, etc? [Please note we have correspondence fees and time must be scheduled outside of session that is scheduled at $150 per hour, these fees are not covered by insurance]

No

Do you drink alcohol?

- Yes

Occasionally, weekends, etc.

Do you use recreational drugs?

- Yes

caffeine, cigarette

Do you have suicidal thoughts?

- No

Have you ever attempted suicide?

- No

Do you have thoughts or urges to harm others?

- No

Have you ever been hospitalized for a psychiatric issue?

- No

Is there a history of mental illness in your family?

- No

If you are in a romantic relationship, please describe the nature of the relationship and months or years together.

Single

Describe your current living situation. Do you live alone, with others. With family, etc...

Alone

What is your level of education? Highest grade/degree and type of degree.

Bachelor's

What is your current occupation? What do you do? How long have you been doing it?

Working in a bank for 5 years

Please check any of the following you have experienced in the past six months

- Trouble concentrating
- Low motivation
- Anxiety
- Fear
- Hopelessness
- Panic

Please check any of the following that apply

- High blood pressure
- Dizziness
- Numbness & tingling

What else would you like me to know?

N/A

Have you seen a mental health professional before?

- No

Specify all medications and supplements you are presently taking and for what reason.

N/A

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

N/A

Who is your primary care physician? Please include type of MD, name and phone number.

N/A