Intake Information Form

Attached are forms, regarding the nature of your concerns, that will help in providing you with the appropriate services. Please complete these forms by providing information on your current circumstances and history, as well as your concerns.

All information is held in strict confidence.

Please have this form completed by your next visit and bring it with you.

Name: Age: Date:

Address:

Home phone: Work phone:

Ok to leave message? Ok to leave message?

Cell phone: Email

Ok to leave message? Ok to email?

Preferred method of contact: Home phone Work phone Cell Email

Date of birth: Sex: Occupation:

Relationship status:

Single Separated Widowed Married Divorced Partnered

With whom do you currently live? (Circle all that apply)

Live alone Friend(s) Children Spouse/Partner and Children Spouse/Partner Parents
Other relatives Other (please specify):

Education:

Some high school High school graduate Some college B.A. Graduate degree

Religious background (optional)

Buddhist Hindu Muslim Catholic Jewish Protestant Other (specify):

Ethnic background (optional):
Native American Caucasian Pacific Islander/Asian African American Latino
Other (specify):

Have you previously received psychological or psychiatric help or counseling?

Have you previously received psychological assessment (testing)?

Has any other member of your family or household previously sought or received psychological or psychiatric help or counseling?

How did you hear about us?

Family information

Spouse/Partner Name:	Age:
Children (Please list all children whether living with you or not) 1. 2. 3. 4. 5.	Age:
Emergency contact name: Address:	Phone number: Relationship to you:

Problem areas.
Please rank up to 3 problems of most concerns to you at this time. Place a "1" next to the problem that troubles you the most, a "2" next to the second most troubling problem and a "3" next to the third most troubling problem.

Educational or vocational choice	Uncontrollable or disturbing thoughts
Employment/Finances	Physical conditions (pain, headaches, insomnia)
Friendships or social life	Anxiety (worries, fears, phobias)
Marriage or couple	Physical or sexual abuse
Family	Habits
Sex	Educational problems or learning disabilities
Legal/Criminal	Eating issues
Memory or concentration	Depression
Behavior problems (attention problems, delinquency)	Other (please specify

How do you feel psychotherapy can best help you?

I certify that the above information is correct to the best of my knowledge.

____________________________________ _______________
Signature Date

Medical Screening Form

Are you currently receiving medical care? Y N
If yes, please describe briefly:

Name of physician in case of emergency: Phone:

Major childhood illnesses:

Other major illnesses or handicaps:

Hospitalizations or serious injuries:
Reason:
When:
Complications or continuing problems (if any):

Current drugs or medications:

Name of medication	Dose per day	Date started
1.		
2.		
3.		
4.		

Have there been any serious illnesses, accidents, deaths or other physical concerns within your family in the past 5 years? Y N If yes, please specify:

If there are any other medical or physical problems which you feel might be important, please explain here: