Betsy Bates Freed, Psy.D. Licensed Clinical Psychologist CA #PSY25652

Intake Form

Name: _____ Date: _____

Address:_____

Date of birth: _____ Social Security #: _____

Phone numbers (Are these numbers where I can leave a confidential voice mail?)

Home_____ Work _____ Cell: _____

Email address (Is this a private email?): _____

Emergency Contact (name and phone number): _____

Referred by: _____

Chief Concern

Please describe the main concern that has brought you to see me:

What are your current and chronic psychological/emotional and/or medical challenges?

Medications

Please list your current medications and dosages (Use back of form, if needed)

_____

Your medical care team

Doctor's name(s): _____ Phone: _____

If you enter treatment with me, may I consult with your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

Occupation/Employer: _____

Previous Occupation(s): _____

Length of time with this employer: _____

Insurance/billing

If you have Medicare & a supplemental policy, or Aetna, please list policy numbers. Otherwise, do you prefer (please circle one) : Credit card Check Monthly billing

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Present relationships

Are you in a current relationship?

If so, how do you get along with your spouse or partner?

Do you have children? If so, what are their ages?

How do you get along with your children?

Briefly describe any other important relationships/friendships in your life. Are you satisfied with how they are going?

Cultural/ethnic/spiritual identity

What cultural, ethnic, and/or spiritual connections do you consider most important to how you see yourself?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services (psychotherapy)? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate details:

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, what medications/doses? Were they effective? Do you take them currently?

Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger/temper	anxiety
appetite	parenting issues	bladder/bowel problems
sleep issues	physical pain	concentration
confidence/self esteem	stress	spiritual issues
depression	divorce	drug use
eating problem	education	energy (high/low)
extreme fatigue	fears	relationship w/parent(s)
finances	friends	guilt
headaches	health problems	inferiority feelings
gambling	loneliness	making decisions
marriage/relationship	memory	suicidal thoughts
nervousness	nightmares	obsessive thinking/compulsions
weight issues	painful thoughts	panic attacks

phobias sexual issues sadness

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Use the following scale: 1– No effect 2– Little effect 3– Some effect 4– Much effect 5– Significant effect 6 --Not Applicable

Marriage/ Relationship

Family

Job/school performance

Friendships

Financial situation

Physical health

Anxiety level

Mood

Eating habits

Sleeping habits

Sexual functioning

Alcohol / drug use

Spiritual issues

Ability to concentrate

Ability to control anger

<u>Assessment Questions</u>

Do you currently consume alcohol? Yes No

Do you feel that you *currently* have a problem with alcohol or drug use? Yes No

In the past, did you have a history of problematic use of alcohol or drugs? Yes No

Have family members or friends expressed concern about your drinking/drug use? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

Would you like help with weight issues? Yes No

If so, BMI or height/weight_____

Have you ever felt so depressed you wanted to harm yourself? Yes No

Have you ever attempted suicide? Yes No Explain:_____

In the past month, have you felt suicidal? Yes No

In the past month, have you felt that you wanted to harm someone else? Yes No

Has anyone in your family attempted or completed suicide? Yes No

Do you have a family history of mental illness, such as depression, anxiety, bipolar disorder, schizophrenia, Alzheimer's disease, etc.? (If yes, please briefly describe)

_____

_____

Do you feel that you are in danger? Yes No

Explain:_____

What do you consider your greatest sources of strength/ coping mechanisms?

_____

_____

OTHER:

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.