Betsy Bates Freed, Psy.D.
Licensed Clinical Psychologist CA #PSY25652
(805) 979-3440

Intake Form

Please share with me whatever information you feel might be helpful in our work together. Your answers will remain confidential.

Name: _____ Date: _____

Address:_____ Date of Birth:_____

Phone numbers: Home_____ Work _____ Cell: _____

Please place an asterisk next to numbers where I can leave a confidential voice mail.
Would you like to receive appointment reminders here? Y ___ N ___

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:

_____

_____

General Health

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Excellent

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Excellent

How many times a week do you generally exercise? _____

What types of exercise do you participate in? _____

Please describe any difficulties with your weight, appetite, or eating patterns:

Please detail your **current** and **chronic** medical issues/challenges (use back of form if necessary for medical history and prescription information):

Please list **prescriptions** and **over-the-counter** medications and dosages.

Your medical care team: Doctors' name(s)/Phone numbers:

_____

If you enter treatment with me, may I communicate with your medical doctor(s) to coordinate your treatment? Yes No Maybe (within limits)

Occupation/Previous Occupation(s): _____

Employer: _____ Length of time with this employer: _____

Insurance coverage

Please list your insurance coverage, plan ID number, and individual identification number if we will be billing Medicare, Aetna, and/or a secondary plan for you.

_____
_____

Childhood and education

Briefly describe your family of origin (parents, siblings, etc.) and your childhood:

_____

_____

Did you have serious illnesses/injuries/physical/emotional trauma as a child?

Present relationships

Are you in a current relationship?

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

Do you have children/grandchildren?

If so, what are their ages?

How do you get along with your children/grandchildren?

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

<u>Past Psychological/Psychiatric Treatment</u>

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? 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, please indicate type, duration, results:

Do you have a **family history** of psychological/psychiatric disorders? Yes No

If so, please describe:

Have you been suicidal in the past month?

Have you ever had thoughts of taking your life? ____ Have you ever acted on these thoughts? _____ If so, please describe what happened:

Has anyone in your family taken their own life or attempted suicide? If so, please describe:

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

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	physical pain
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	weight issues
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work
COVID-19 fears	COVID-19 losses	Recovery issues/Covid-19

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 - Doesn't apply to me

Marriage/ Relationship

Family

Job/school performance

Friendships

Financial situation

Physical health

Anxiety level

Mood

Eating habits

Sleeping habits

Sexual functioning

Alcohol / drug use

Ability to concentrate

Ability to control anger

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

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

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

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

If yes, please describe:

Do you smoke or use other tobacco products? Yes No

If so, would you like help in quitting smoking? Yes No Perhaps

Do you feel that you are in danger? Yes No (Please explain)

More about you:

What normally brings you joy? _____

Have you recently had difficulty experiencing that sense of joy? Yes No

How would you describe important aspects of your cultural/ethnic identity that would be important for me to consider as your psychologist?

What do you consider your greatest strengths/ sources of resilience?

_____

_____

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.*