CLINICAL INTAKE FORM

Ron Rice, PHD - Clinical Psychologist

(We will keep this information strictly confidential)

Client Name: _____ Date: _____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Social Security Number: _____

Address: _____

_____

_____

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

Work Phone: _____ May we leave a message? ☐ Yes ☐ No

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

E-mail address: _____

Text: _____ May we leave a message? ☐ Yes ☐ No

May we communicate with you by e-mail? ☐ Yes ☐ No

Marital Status: ☐ Never Married ☐ Partnered ☐ Married ☐ Separated ☐ Divorced

Emergency Contact Name: _____

Relationship: _____

Address: _____

Phone: _____

Current Employment: (Name, address, and phone number):

_____

_____

_____

Have you previously received psychological counseling? ☐ Yes ☐ No
If yes, please describe when, where and why:

Are you currently taking prescribed psychiatric medications (antidepressants or others)?
☐ Yes ☐ No

Please describe the problems you most wish help with right now:

How would you describe the intensity of the problems or concerns that brought you in?

How long have you had the current problems?

How would you describe your current appetite?
☐ About the same ☐ Less than normal ☐ More than normal

How would you describe your recent sleeping?
☐ About the same ☐ Problems getting to sleep ☐ Problems staying asleep
☐ Problems getting to sleep and staying asleep

How would you describe your current sexuality?
☐ About the same ☐ Less sexual interest ☐ More sexual interest

Do you currently feel depressed? ☐ Yes ☐ No

Do you have stress on the job? If so, please describe.

If married, how would you describe your marriage?

Have you ever experienced a panic attack? If so when and how often?

If you have had a panic attack, do you fear leaving the house because of concerns about having another panic attack?

Are you afraid to drive? ☐ Yes ☐ No

Do you find that you worry all the time? ☐ Yes ☐ No

Are you afraid to fly on an airplane? ☐ Yes ☐ No

How many alcoholic beverages do you typically drink in a week?

☐ None ☐ 1-4 ☐ 5-8 ☐ 9-14 ☐ More than 14

How many times a week do you typically use recreational drugs?

☐ None ☐ 1-4 ☐ 5-8 ☐ 9-14 ☐ More than 14

If you use recreation drugs, please describe the types of drugs you use and how you use them:

Describe any problems or concerns you have about sexual functioning:

HEALTH ISSUES

How would you describe your overall health?

Describe any current medical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

What medications are you presently taking?

Describe your exercise habits:

Describe anything else you believe is relevant to your treatment:

Please provide name, address, and phone number of your primary care physician:

May we discuss your treatment with your primary care physician? ? ☐ Yes ☐ No
If yes, please sign and date below:

Client Name (Printed): _____

Client Signature: _____

Date: _____