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: ____

____

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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: ____

CLIENT CONCERNS

PLEASE CHECK THE ITEMS YOU WOULD LIKE TO ADDRESS IN THERAPY

CAREER/WORK

___ Career Choice
___ Financial Concerns
___ Other ______________________
___ Difficulties at work
___ Problems making decisions
___ Personality Conflicts
___ Overwork/stress

HEALTH CONCERNS

___ Weight Change
___ Eating pattern disorder
___ Tired all the time
___ Concerns about drugs
___ Bingeing
___ Difficulty Sleeping
___ Headaches
___ Concerns about Alcohol
___ Purging
___ Lack of Energy
___ Dizziness
___ Nightmares

PERSONAL CONCERNS

___ Suicidal
___ Anxious
___ Unhappy
___ No self-confidence
___ Feeling Angry
___ Dealing with loss
___ Trouble Concentrating
___ Feeling panicky
___ Sensitive
___ Worried
___ Not feeling at all
___ Other ________________
___ Depressed
___ Feeling Inferior
___ Feelings easily hurt
___ Fearful
___ Dealing with death

SOCIAL RELATIONSHIPS

___ Shy with people
___ Difficulty making friends
___ Feeling lonely
___Problems maintaining relationship
___ Feeling lonely
___ Fighting in personal relationships
___Difficulty relating to people
___ Other _____________

FAMILY RELATIONS/SPOUSE

___ Sexual concerns
___ Verbal abuse
___ Marital concerns
___ Physical abuse
___ Fighting
___ Financial Stress

PERSONAL GOALS

___ Develop assertiveness skills
___ Develop clearer personal identity
___ Develop better coping skills
___ Develop more realistic expectations
___ Increase awareness of emotional response
___ Accept personal limitations
___ Clarify personal goals and values

___ Other ____

Name: ____ Date: _____________________________