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: ____________________________

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? Is 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
___ Difficulties at work
___ Personality Conflicts
___ Financial Concerns
___ Problems making decisions
___ Overwork/stress
___ Other _____________________

HEALTH CONCERNS

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

PERSONAL CONCERNS

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

SOCIAL RELATIONSHIPS

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

FAMILY RELATIONS/SPOUSE

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

PERSONAL GOALS

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

Name: ______________________

Date: __________