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CLIENT INTAKE FORM

Today's date: _____

Full Name: _____

Date of birth: _____ Age: _____

Home address:

_____

City: _____ State:_____ Zip:_____

Home/Cell phone numbers : _____

E-mail: _____

Calls will be discreet, but please indicate any restrictions:

_____

How did you hear about my practice?_____

If referred, who gave you my name to call?_____

Name: _____ Phone:_____

With your written consent, may I have your permission to thank this person for the referral? ❑ Yes ❑ No

If some kind of emergency arises and I need to reach someone close to you, whom should I call?
Name: _____ Phone: _____

Relationship: _____

YOUR MEDICAL CARE

It is recommended that you have a physical examination conducted every six months by your primary care doctor to rule out any medical issues that could underlie an emotional/psychological problem. At times, and only with your written consent, it may be important for me to consult with other professionals such as primary care doctors and psychiatrists on behalf of your treatment.

Do you see a medical professional for psychiatric medications? ❑ Yes ❑ No
If so, please list name of medication(s) and dosage

_____

With your written consent, may I contact the *psychiatrist*? ❑ Yes ❑ No
Doctor's name: _____ Phone: _____

Address: _____

With your written consent, may I contact your *primary care doctor*? ❑ Yes ❑ No
Doctor's name: _____ Phone: _____

Address: _____

GENERAL HEALTH INFORMATION

1. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list or describe sleep problems you are currently experiencing:

_____

_____

2. Are you currently experiencing significant sadness or grief? □ No □ Yes
If yes, for approximately how long? _____

3. Are you currently experiencing anxiety, excessive nervousness, or panic attacks? □ No □ Yes
If yes, for approximately how long? _____

4. How would you rate your level of anxiety on most days (1-10, 10 = Highest)_____

5. How would you rate your overall mood on most days (1-10, 10 = Very Good) _____

6. Please list or describe significant health problems you are having:

_____

_____

_____

7. Please let me know if you experience any of the following symptoms on a frequent basis (Please circle):

Upset stomach
Nausea
Diarrhea
Migraine headaches
Tension headaches
Irritable bowl
Abdominal pain
Unexplained Joint & back pain
Blurry or tunnel vision
Dizziness/Vertigo