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PERSONAL DATA INFORMATION

DATE: _____

NAME: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

STREET ADDRESS: _____

CITY: _____ ZIP CODE: _____

AGE: _____DATE OF BIRTH: _____

EMAIL: _____

RELATIONSHIP STATUS:

- ☐ MARRIED
- ☐ PARTNERED
- ☐ SINGLE
- ☐ SEPARATED
- ☐ DIVORCED
- ☐ WIDOWED
- ☐ DATING

NUMBER OF YEARS IN THIS RELATIONSHIP STATUS? _____

DO YOU HAVE A SPIRITUAL PRACTICE? [ ] YES [ ] NO

REFERRED BY: _____

EMERGENCY CONTACT INFORMATION:

NAME OF EMERGENCY CONTACT: _____

PHONE NUMBER: _____

RELATIONSHIP TO YOU: _____

ARE YOU CURRENTLY IN ANY OTHER GROUPS, COMMUNITY SUPPORTS OR THERAPY? [ ] Yes [ ] No

IF YES, PLEASE DESCRIBE: _____

<u>Psychiatric Treatment History</u>

Outpatient psychiatric treatment? [ ] Yes [ ] No

IF SO PLEASE PROVIDE:

NAME:

ADDRESS:

DATES:

WAS YOUR THERAPY EXPERIENCE HELPFUL? [ ] Yes [ ] No

IF YOU CHECKED YES, WHAT WAS HELPFUL?

_____

_____

_____

IF YOU CHECKED NO, WHAT DIDN'T WORK FOR YOU?

_____

_____

_____

Psychiatric hospitalization [ ] Yes [ ] No

Total number of admissions? _____

Date of last admission: _____

Hospital diagnosis: _____

Have you ever attempted suicide? [ ] Yes [ ] No

Are you considering suicide now? [ ] Yes [ ] No

CURRENT PSYCHIATRIC DIAGNOSIS: _____

CURRENT PRESCRIBED MEDICATIONS:

_____

_____

_____

CURRENT OVER THE COUNTER MEDICATIONS:

_____

_____

_____

ANY SERIOUS OR CHRONIC MEDICAL CONDITIONS?

_____

_____

_____

ANY SERIOUS ACCIDENTS/HEAD INJURIES/SEIZURES OR TRAUMATIC BRAIN INJURIES? IF YES, PLEASE PROVIDE DETAILS.

_____

_____

_____

Chemical Dependency Treatment History:

CD outpatient treatment? [ ] Yes [ ] No

Please describe with dates and names of treatment providers:

_____

_____

_____

CD hospitalization: [ ] Yes [ ] No

CD residential treatment:

Dates: _____

Name of facilitie(s): _____

Do you have any medical concerns"? [ ] Yes [ ] No

Please describe: _____

Do you have any psychiatric concerns? [ ] Yes [ ] No

WHY ARE YOU SEEKING THERAPY NOW?

_____

_____

_____

WHAT ARE YOUR GOALS?

_____

_____

_____

WHAT ARE YOU SEEKING? (PLEASE CHECK ALL THAT APPLY)

- ☐ INDIVIDUAL THERAPY?
- ☐ TRAUMA THERAPY?
- ☐ CODEPENDENCY GROUP?

☐ RELATIONSHIP THERAPY?
☐ FAMILY THERAPY?
☐ SUBSTANCE ABUSE TREATMENT?

ANY OTHER TYPE OF THERAPY NOT MENTIONED HERE? [ ] YES [ ] NO

IF SO, PLEASE EXPLAIN: _____

_____

_____

_____

Do you use alcohol? _____ How much per week? _____

What is your alcohol of choice?_____

Do you use any of the following and please check all that apply:

Marijuana/Hashish

First use:_____

Last use:_____

Benzodiazepines

First use:_____

Last use:_____

ethamphetamines/Crank

First use:_____

Last use:_____

Cocaine/Crack

First use:_____

Last use:_____

Club Drugs (Ecstasy, Poppers etc.)

First use:_____

Last use:_____

Pain Medications

First use:_____

Last use:_____

Heroin/Methadone

First use:_____

Last use:_____

Inhalants

First use:_____

Last use:_____

Nicotine

First use:_____

Last use:_____

Caffeine

First use:_____

Last use:_____

Over the Counter Cough Syrup

First use:_____

Last use:_____

Do you feel you have an alcohol or drug issue?

Has your use of alcohol or any other drugs caused a problem for you?

Has your use of alcohol or any other drugs caused a problem for you at work?

Has your use of alcohol or any other drugs caused relationship or family problems? If yes, with whom: _____

How often do you use mind altering substances? Daily [ ] Weekly [ ]

Weekends [ ] Monthly [ ]

Is it difficult for you to control your intake of alcohol/drugs?
[ ] Yes [ ]No

Any previous treatment for substance abuse?

Dates:

Locations:

History with the law:

DUI: [ ] Yes [ ] No

Other incidents with the law [ ] Yes [ ] No

Please explain: _____

When? _____

_____

_____

_____

Have you ever been in a relationship where your partner hit slapped, kicked, choked or otherwise physically hurt you? [ ] Yes [ ] No

In the last 12 months has your partner kicked, slapped, choked or otherwise physically hurt you? [ ] Yes [ ] No

Are you afraid of your partner? [ ] Yes [ ] No

In the last 12 months have you been forced to participate in unwanted sex? [ ] Yes [ ] No

Family history of drugs/alcohol problems [ ] Yes [ ] No

Relationship to you: (e.g. sister, brother, etc.) _____

Family history of psychiatric problems:

Relationship to you - _____

Diagnosis: _____

Relationship to you- _____

Diagnosis: _____

Check your highest completed level of education?

- ☐ Grammar school:
- ☐ Middle school:
- ☐ High school:
- ☐ Some college:
- ☐ College graduate:
- ☐ Post graduate:
- ☐ Doctorate:

Employment:

Are you employed? [ ] Yes [ ] No

Company name: _____

What do you do there? _____

Full time? [ ] Part time? [ ]

Does your desire for treatment have anything to do with your job?

[ ] Yes [ ] No

If yes, please explain: _____

Are there any Guns/Weapons in your home? [ ] Yes [ ] No

If yes, please keep them under lock.

Thank you for completing this intake form. It will be reviewed with you during our first meeting.

Ann Schiebert, PsyD