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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: _____

Psychiatric Treatment History

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