

KATHRYN S. STEINMAN, PSY.D.
Licensed Psychologist

PATIENT INTAKE FORM

DATE: _____

Patient Name: _____

Patient Address: _____

Phone: _____ (home) _____ (cell)

E-mail Address: _____

Referred by: _____

Reason for Initial Visit: _____

PERSONAL INFORMATION

Date of Birth: _____

Age: _____

Occupation/Employer: _____

Relationship Status: _____ Single _____ Dating _____ Married _____ Separated
_____ Divorced _____ Widowed _____ Other (Specify: _____)

Children (names and ages): _____

Place of Birth: _____

Place of Upbringing: _____

Mother (name, age, occupation): _____

Father (name, age, occupation): _____

Sibling (s) (name (s) and age (s)): _____

Please indicate any issues of concern regarding relationship with family while growing up:

EDUCATION

Graduate School

Please indicate institution(s) attended, degree, specialty area, and year of graduation.

College

Please indicate institution attended, degree, major, and year of graduation.

High School

Please indicate school attended, date of graduation, and overall GPA.

Have you ever been diagnosed with a learning disability? _____ Y _____ N

If yes, please explain: _____

Please indicate any outstanding academic strengths and weaknesses:

MEDICAL INFORMATION

Have you had any serious diseases, illnesses, or injuries (past or present): _____

Primary care physician (name and number): _____

CURRENT SYMPTOMS OR ISSUES OF CONCERN

Please check all that apply.

<u>Symptom/Issue</u>	<u>Symptom/Issue</u>
_____ Fatigue	_____ Perfectionism
_____ Stress	_____ Panic Attacks
_____ Sleep problems	_____ Thoughts of Harming Self
_____ Sadness/Depression	_____ Physical Problems
_____ Anger	_____ Dizziness
_____ Worry	_____ Weight Change
_____ Memory problems	_____ Loneliness/Isolation
_____ Low Energy	_____ School/Work Difficulties
_____ Eating Behavior Issues	_____ Obsessive/Compulsiveness
_____ Nervousness	_____ Impulsiveness
_____ Social problems	_____ Heart Palpitations
_____ Family problems	_____ Sick Often
_____ Mood Swings	_____ Headaches
_____ Low Self-esteem	_____ Easily Distracted
_____ Hopelessness	_____ Thoughts of Harming Others
_____ Irritability	_____ Nightmares
_____ Poor Concentration	_____ Disorganized Thoughts
_____ Anxiety	_____ Violent Behavior
_____ Substance Abuse	

PSYCHIATRIC HISTORY

Did you ever have any emotional/psychological difficulties as a child? _____ Y _____ N

If yes, please explain: _____

Were you ever considered as having "behavioral problems" as a child? _____ Y _____ N

If yes, please explain: _____

Have you ever been in psychotherapy before? _____ Y _____ N

If yes, please explain: _____

Have you ever been hospitalized for a psychiatric problem? _____ Y _____ N

If yes, please explain: _____

Have you ever had thoughts of hurting yourself? _____ Y _____ N

If yes, please explain: _____

Have you ever intentionally hurt yourself? _____ Y _____ N

If yes, please explain: _____

Have you ever had thoughts of hurting someone else? _____ Y _____ N

If yes, please explain: _____

Have you ever attempted to hurt someone else? _____ Y _____ N

If yes, please explain: _____

Do you use/abuse alcohol/illegal substances? _____ Y _____ N

If yes, please explain: _____

Is there a family history of psychiatric problems (including alcohol or substance abuse)?

If yes, please explain: _____ Y _____ N

Are you currently seeing a psychiatrist? _____ Y _____ N

If yes, please provide his/her name and phone number: _____

MEDICATIONS

Please list all medications (including vitamins) you are currently taking, including dosage and frequency if known: _____

EMERGENCY CONTACT

Name and number of person to contact in case of an emergency:

Relationship to Patient: _____

I certify that the above information is accurate. I understand that this information will be included in my clinical record and will be used and disclosed only as described in the document explaining professional services and business policies, as well as the "Notice of Policies and Practices to Protect the Privacy of Patients' Health Information."

Patient Signature

Date

Printed Name