**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:** _____

_____

## CURRENT SYMPTOMS OR ISSUES OF CONCERN

Please check all that apply.

| | Symptom/Issue | | Symptom/Issue |
|---|---|---|---|
| _____ | 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 | | |

**7988 Old Georgetown Road / Suite 8-A / Bethesda, MD 20814**
**drkathryn@steinmantherapy.com / Phone: 301.787.4459**

**PERSONAL INFORMATION**

**Date of Birth:** _____

**Age:** _____

**Occupation/Employer:** _____

**Relationship Status:** _____ **Single** _____ **Dating** _____ **Married** _____ **Separated**

_____ **Divorced** _____ **Widowed** _____ **Other (Specify:** _____**)**

**Significant Other (name, age, occupation):** _____

**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:

_____

**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)? _____ Y _____ N
If yes, please explain: _____
_____

Are you currently seeing a psychiatrist? _____ Y _____ N
If yes, please provide his/her name and phone number:
_____

**MEDICAL INFORMATION**

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

Primary care physician (name and 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: _____

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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**