



PSYCHOLOGICAL INTAKE

Today's Date: _____

Client Name: _____ Gender: M F

Date of Birth: _____ Age: _____

Client's Social Security #: _____

Street Address: _____

City _____ State _____ Zip _____

Employer/School: _____

Family Members at Home: _____

Emergency Contact: _____

Parent/Guardian (If under 18) _____ Phone _____

Whom may I thank for referring you? _____

Reason for Visit: _____

PREFERRED METHOD OF CONTACT:

Cell phone: _____

Home phone: _____

Work Phone: _____

Email: _____

If you live with another person, may I leave a message with him/her or on your home phone?

YES NO

PATIENT NAME: _____
DATE of REPORT: _____

MARITAL HISTORY:

Current Marital Status:

___ married ___ single ___ divorced ___ separated ___ widowed

Name of Spouse/Significant Other: _____

Is this your first marriage/co-habitation? YES NO

Number of Years Married/Living Together: _____

Briefly describe your relationship with your spouse/significant other:

FAMILY MEMBERS:

SIBLINGS:	AGE:	RELATIONSHIP:	WHERE
		(none, fair, good, poor, great)	LIVE?

- 1.
- 2.
- 3.
- 4.
- 5.

CHILDREN:

- 1.
- 2.
- 3.
- 4.
- 5.

Mother's Name: _____ **Age:** _____

Mother's Education: _____; **Occupation:** _____

Father's Name: _____ **Age:** _____

Father's Education: _____; **Occupation:** _____

Step Mother's Name: _____ **Age:** _____

Step Father's Name: _____ **Age:** _____

Parents Who Raised You: (Names): _____

Your age when parent(s) passed away: _____

Your age when parents separated/divorced: _____

Number of years your parents were married:

PATIENT NAME: _____
DATE of REPORT: _____

DEVELOPMENTAL HISTORY:

Place of Birth: _____
If born in another country, how old were you when you came to the U.S.? _____
Childhood Illness(es): _____
Highest Level of Education Achieved: _____
Religion You Were Raised: _____
Religion Currently Practiced: _____
Other Languages Spoken: _____

MEDICAL HISTORY:

Primary Care Physician: _____
Phone: _____
Date of last visit: _____

In the event of an emergency, do you give your consent for me to contact your physician and/or contact/discuss treatment with the emergency room? YES NO

Do you give consent for Dr. Susan Mendelsohn to contact your physician on behalf of your ongoing psychological treatment? YES NO

Medical Hospitalization(s): Serious Injury or Illness:

Date/Description: _____
Date/Description: _____

Please provide any additional medical history that you feel is pertinent for Dr. Susan Mendelsohn to know about you:

PATIENT NAME: _____
DATE of REPORT: _____

MENTAL HEALTH HISTORY:

PREVIOUS PSYCHOLOGICAL COUNSELING: (Please provide dates of therapy, purpose and therapist):

PREVIOUS PSYCHIATRIC/RESIDENTIAL HOSPITALIZATIONS: (please provide dates, purpose and treatment center/hospital):

MEDICATIONS:

PAST:	REASON:	CURRENT:	REASON:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SUICIDAL HISTORY:

_____ Thoughts: List dates: _____
_____ Attempts: List dates: _____
_____ Current? Explain: _____

HISTORY OF PHYSICAL ABUSE/ASSAULT: Y N (If yes, please describe):

HISTORY OF SEXUAL ASSAULT/ABUSE Y N (If yes, please describe):

PATIENT NAME: _____
DATE of REPORT: _____

DO YOU CURRENTLY USE:

NICOTINE? Y N How much? _____

CAFFEINE? Y N How often/much? _____

ALCOHOL? Y N How often/much? _____

DRUGS? Y N Which ones? How often? _____

Have you ever been treated for drug/alcohol abuse? Y N

If yes, give dates and agency: _____

Do you feel that the use of drugs/alcohol are interfering in your life today? Y N

Explain:

SEXUAL ORIENTATION

____ Heterosexual

____ Homosexual (male)

____ Lesbian

____ Bisexual

____ Uncertain/Questioning

LEGAL ISSUES

Have you ever sued a physician or mental health provider? Y N

If YES, please describe below:

Are you currently involved in any lawsuits or police issues? Y N

If YES, please describe below:

Have you been involved in any lawsuits or police issues in the past? Y N

If YES, please describe below:

Please provide additional legal information you may find pertinent for Dr. Susan Mendelsohn to be aware of:

PATIENT NAME: _____
DATE of REPORT: _____

FAMILY HISTORY of MENTAL ILLNESS:

Please list all relatives who are suffering from a mental illness. Include the following:
a) which relative, b) which illness, c) whether or not they are being treated, d) if they are currently taking medications for the illness, e) if the medication is helping their illness, f) whether they are employed or on disability, g) how the illness has affected the family. Include substance abuse as a mental illness:

FAMILY MEDICAL HISTORY:

Please list all first degree relatives and their medical history including diabetes, heart disease, cancer, thyroid disease, etc. Include whether they are still surviving or have deceased.

MISCELLANEOUS INFORMATION:

Please share any other information that you would like to share with Dr. Susan Mendelsohn during your initial session that you would like for me to know about you today.

THANK YOU for taking time to complete this very important form.