Kevin Brock, Ph.D.
Licensed Clinical Psychologist

Intake Information Form

Note: If you were a patient here before, please fill in only the information that has changed.

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____

Age: ____

Nicknames or aliases: _____

Home street address: _____

Apt.: _____

City: _____ State: _____

Zip: _____

Home/evening phone: _____

e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions:

_____

B. Referral: How did you hear about me?

C. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic

❑ Buddhist ❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

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How important are spiritual concerns in your life?

_____

Ethnicity/national origin: _____ Race: _____

or other similar way you identify yourself and consider important:

_____

D. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____Phone: _____

Address:

_____

_____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. Your current employer

Employer: _____

Address: _____

Work phone: _____ or other means of communication

_____

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_____

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F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____

Relationship: _____

Address:_____

_____

Significant other/nearest friend or relative not residing with you:

_____

G. Your education and training

Dates		Schools
From	To	

B. Chief concern

Please describe the main difficulty that has brought you to see me:

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Severity of the above problem(s) 0-10:

Suicidal Thoughts? Indicate yes or no. Now:_____

In the Past?_____

If yes please describe:

Suicidal Actions? Dates of attempt(s):

Were you hospitalized?_____

C. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what?

With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

When? From whom? Which medications? For what?

With what results?

D. Relationships in your family of origin.

Please describe the following:

1. Your parents' relationship with each other:

2. Your relationship with each parent and with any other adults present:

3. Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties:

4. Your relationship with your brothers and sisters, in the past and present:

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E. Abuse history:

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect.

E = Emotional, such as humiliation, etc.

Your age(s):

Kind of Abuse, please circle all that apply: S P N E

By Whom?:

Effects of You:

F. Present relationships

1. How do you get along with your present spouse or partner?

2. How do you get along with your children?

3. Your important friends, past and present:

Names:

Good parts of relationship:

Bad parts of relationship:

G. Chemical use

1. How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____.

How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)?

How many "energy drinks"? ____

How often do you use No Doz or similar caffeine pills? _____ .

2. How much tobacco do you smoke or chew each week?

_____

3. Have you ever felt the need to cut down on your drinking? ❑ No ❑ Yes

4. Have you ever felt annoyed by criticism of your drinking? ❑ No ❑ Yes

5. Have you ever felt guilty about your drinking? ❑ No ❑ Yes

6. Have you ever taken a morning "eye-opener"? ❑ No ❑ Yes

7. How much beer, wine, or hard liquor do you consume each week, on the average?

_____

8. Are there times when you drink to unconsciousness, or run out of money as a result of drinking?

❑ No ❑ Yes

9. Have you ever used inhalants ("huffing"), such as glue, gasoline, or paint thinner? ❑ No ❑ Yes

If yes, which and when?

Which drugs (not medications prescribed for you) have you used in the last 10 years?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

H. Legal history

1. Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain:

2. Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain:

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?

❑ No ❑ Yes. If yes, please explain:

5. Your current attorney's name, IF COURT ORDERED:

Phone: _____

6. Are there any other legal involvements I should know about?:

What are some things you like about yourself?

What are some things you most enjoy?

How would you like your life to be in 5 years?

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I. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

Please do not write below this line.

_____

J. Follow-up by clinician

Based on the responses above and on ❑ interview data ❑ records I reviewed ❑ other information I have asked the client to complete and/or I have completed the following forms:

❑ Chemical use survey ❑ Suicide risk assessment summary and recommendations ❑ Mental status evaluation report

Other: