# CLIENT INTAKE INFORMATION

**Megan E. Pietrucha, Psy.D.**
**Licensed Clinical Psychologist**

## CONTACT INFORMATION

**Name:** _____

**Home Address:** _____ **Home Phone Number:** _____
*(Street Address, Apartment Number)*

_____ **Cell Phone Number:** _____
*(City, State, Zip Code)*

**Place of Employment:** _____ **Title/Position:** _____

**Business Address:** _____ **Work Phone Number:** _____
*(Street Address, Apartment Number)*

_____
*(City, State, Zip Code)*

**E-mail Address:** _____

Is it acceptable to contact you by telephone at home? Y / N Leave message? Y / N

Is it acceptable to contact you on your cell phone? Y / N Leave message? Y / N

Is it acceptable to contact you by telephone at work? Y / N Leave message? Y / N

Is it acceptable to e-mail information to you from time to time? Y / N

**Emergency Contact:** _____ _____ _____
*Name* *Phone* *Relationship to you*

** Please note: Dr. Pietrucha will only contact this person in the case of an extreme emergency, such as if your life is in danger.*

## BACKGROUND INFORMATION

**Date of Birth:** _____/____/_____ **Age:** _____
*(Month/Day/Year)*

**Gender *(check one)***: Female _____ Male _____ Transgender _____ (Specify _____)

**Ethnic/Racial Identification:** _____

**Sexual Orientation:** _____

**Relationship Status *(check one)*:**

Single _____
Married/Partnered _____
Separated _____
Widowed _____
Other _____

**Current primary role *(check one)*:**

Wage earner _____
Home care/child rearing _____
Student _____
Other _____

**Partner's occupation:** _____ **Length of time in current relationship:** _____

**Your religious/spiritual affiliation:** _____

**Religious/spiritual affiliation of your family of origin:** _____

**Highest level of education for self and family *(check one for each)*:**

| **Education Level** | ***Self*** | ***Mother*** | ***Father*** | ***Partner*** |
|---|---|---|---|---|
| Post-graduate training | | | | |
| Four year college degree | | | | |
| Two yr college/Trade school | | | | |
| High school/GED | | | | |
| Some high school | | | | |
| Elementary school | | | | |
| No formal education | | | | |
| Other (specify) | | | | |

Is your mother currently living? Y / N Mother's current age (or age at death): _____

Is your father currently living? Y / N Father's current age (or age at death): _____

**Please list your siblings and their ages below (if applicable):**

| **Name** | **Gender** | **Current age (or age at death and date of death)** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Please list your children and their ages below (if applicable):**

| **Name** | **Gender** | **Current age (or age at death and date of death)** |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |

**Has anyone in your family struggled with any of the following issues? If so, who?**

| | | | |
|---|---|---|---|
| Alcohol or other drug abuse | Yes | No | *Relationship to you*_____ |
| Eating Problems | Yes | No | *Relationship to you*_____ |
| Depression/Mood Disorder | Yes | No | *Relationship to you*_____ |
| Physical Abuse | Yes | No | *Relationship to you*_____ |
| Sexual Abuse or Assault | Yes | No | *Relationship to you*_____ |
| Emotional Abuse or Neglect | Yes | No | *Relationship to you*_____ |
| Physical or Learning Disability | Yes | No | *Relationship to you*_____ |
| Chronic Health Problems | Yes | No | *Relationship to you*_____ |
| Gambling Problem | Yes | No | *Relationship to you*_____ |
| Criminal Activity | Yes | No | *Relationship to you*_____ |

## PHYSICAL/MEDICAL INFORMATION

Are you currently taking any prescription medications? Y / N

Are you currently taking any over-the-counter medications? Y / N

Please list any medications below:

| Medication | Dosage per day | Taking this since (approximate date) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

When was your most recent physical examination? _____

Name of Primary Care Physician: _____

How often do you exercise? _____

What activities do you do for exercise and about how much time do you spend doing each? _____
_____
_____

Please list any health problems and their duration: _____
_____
_____

Current Height: _____ Current Weight: _____

Lowest Adult Weight: _____ When? _____

Highest Adult Weight: _____ When? _____

Are you currently trying to gain or lose weight? Y / N

If so, why? _____

## CURRENT AND PAST DIFFICULTIES

***Please indicate the extent to which each of the following issues is currently troubling you or has troubled you in the past by writing "now" or "past" in the corresponding column.***

| Issue | *Not at all* | *Mild* | *Moderate* | *Severe* |
|---|---|---|---|---|
| Satisfaction at work | | | | |
| Relationships with co-workers | | | | |
| Procrastination, motivation, time management | | | | |
| Relationships with friends | | | | |
| Relationship with romantic partner | | | | |
| Loss/death of a significant person | | | | |
| Relationship breakup | | | | |
| Sexual concerns | | | | |
| Coming out issues | | | | |
| Pregnancy/abortion issues | | | | |
| Sexually transmitted disease | | | | |
| Relationships with parents/ family of origin | | | | |
| Relationships with your children | | | | |
| Childhood sexual abuse/molestation | | | | |
| Childhood physical abuse | | | | |
| Childhood emotional abuse/neglect | | | | |
| Adult physical or emotional abuse | | | | |
| Rape/sexual assault | | | | |
| Sexual harassment | | | | |
| Discrimination/oppression | | | | |
| Legal matters | | | | |
| Financial concerns | | | | |
| Spiritual/religious concerns | | | | |
| Shyness/assertiveness | | | | |
| Self-esteem, self-confidence | | | | |
| Loneliness | | | | |
| Sadness, depression | | | | |
| Anxiety, nervousness, fears, worries | | | | |
| Irritability, anger, hostility | | | | |
| Mood fluctuation | | | | |
| Crying spells | | | | |
| Suicidal feelings/behavior | | | | |
| Hallucinations | | | | |
| Coping with physical disability | | | | |
| Chronic health problems | | | | |
| Physical stress (headaches, stomach pain, muscle tension, etc.) | | | | |
| Fatigue | | | | |
| Sleeping problems | | | | |
| Eating problems | | | | |
| Alcohol and/or other drugs | | | | |
| Other (_____) | | | | |

Have you ever seriously considered suicide? Y / N When? _____

Have you ever made a suicide attempt? Y / N When? _____

Has anyone close to you ever attempted suicide? Y / N Relationship to you: _____

## RELATIONSHIP QUALITY

**Please rate the quality of your current relationships by checking the appropriate boxes below.**

| **Relationship** | ***Terrible*** | ***Poor*** | ***Fair*** | ***Good*** | ***Excellent*** | ***N/A*** |
|---|---|---|---|---|---|---|
| Mother | | | | | | |
| Father | | | | | | |
| Partner | | | | | | |
| Male friends | | | | | | |
| Female friends | | | | | | |
| Children | | | | | | |
| Siblings | | | | | | |

Have you ever felt unsafe or intimidated in a personal relationship? Y / N

Have you ever intimidated, harassed, or injured a past or present partner? Y / N

## THERAPY HISTORY

Have you received psychotherapy or counseling before? Y / N

If so, when and for how long? _____

Where? _____
*(E.g., community mental health center, private therapist, college counseling center, inpatient/hospitalization, etc.)*

Have you ever been hospitalized for psychiatric reasons? Y / N

If so, when and for how long? _____

Where? _____
*(hospital, city, and state)*

**In which types of treatment (if any) have you participated? *(Please check all that apply.)***

Individual psychotherapy _____
Group counseling _____
Couples counseling _____
Family psychotherapy _____
Psychiatric medication _____
Other _____ *Please specify*_____

**What was most helpful about your past therapy (if applicable)?** _____
_____
_____
_____

**What was least helpful about your past therapy (if applicable)?** _____

## CURRENT GOALS

**In a few sentences, please describe what brings you to therapy:**

**What do you hope to achieve through doing inner work? How would you like your life to change?**_____

**Describe some of your strengths:**

**What are you currently doing to take care of yourself?**_____

**Who referred you to therapy?** ***(Please check all that apply.)***

- **Self** _____
- **Friend** _____
- **Partner** _____
- **Relative** _____
- **Other** _____ ***Please specify***_____

**Do you have any questions or concerns about beginning our work together?** _____