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New Patient Intake Form

Please provide the following information and answer the questions below.
Information you provide here is protected as confidential information.

Today's Date: ___________________________ Social Security Number: __________________________________

Your Name: ____
(First, Middle, & Last)

Home Street Address: ____ Apt. ______________

City: ____________________________________ State: _________________ Zip: ___________________________

Telephone Number: (_____) __________________________ (May I leave a message/text?) ❑ Yes ❑ No
Please Note*: Text correspondence is not considered to be a confidential medium of communication.

Email: ____ (May I email you?) ❑ Yes ❑ No
Please Note*: Email correspondence is not considered to be a confidential medium of communication.

*NOTE: I recommend communicating with me directly using the secure communication platform Spruce, downloadable at the following link: **https://spruce.care/carajeanemesphd**

Date of Birth: ________________________ Age: _______________ Gender Identity: _______________________

Sexual Orientation/Identity: ____

Racial/Ethnicity Identity: ____

Spiritual/Religious Identity: ____

Spiritual/Religious Involvement: ❑ None ❑ Some/Irregular ❑ Active

With whom do you currently live: ____

Relationship status: ❑ Single/Never Married ❑ Domestic Partnership ❑ Married
❑ Separated ❑ Divorced ____ times ❑ Widowed __ times
❑Dating/Not Living Together ❑Dating/Living Together ❑ Other ___________

Do you have children/ages of children? ____

Do you have pets: ____

Name of Emergency Contact: ____________________________ Relationship to You: _____________________
Emergency Contact Telephone Number: (_____) __________________________

What are the main difficulties/presenting issue(s) that motivated you to seek therapy at this time? ____________
____

How long have you been coping with this? ____

What is the severity level of your current distress (scale of 1-10, 10 being worst)? ________________________

What do you hope to accomplish in therapy? ____
____

Educational Level: ❑ Some High School ❑ GED or High School Graduate
❑ Some College ❑ Four-Year Degree
❑ Currently in College ❑ Graduate Education, Specify: __________________

To your knowledge, did you have any developmental delays, special education, or grade retention? __________
____

Employment Status: ❑ Part-Time ❑ Full-Time ❑ Unemployed
❑ Stay-at-home Parent ❑ Disabled ❑ Retired
❑ Student ❑ Self-Employed ❑ Other

Occupation/employer: ____

Military History: Years in Service: ___________ Branch: __________________ Discharge Rank: ____
Military Occupation: ____

Do you have any legal problems/history of arrests? ____

Do you have a worker's compensation claim/injury? ____

Are you court-ordered or court-recommended for therapy? ____

Your Medical Doctor/Clinic: __________________________ Telephone Number: (_____) ________________

Doctor's Address: ____ Suite ________________

City: __________________________________ State: ________________ Zip: _________________________

If you enter treatment with me, may I coordinate your care with your medical doctor? ❑ Yes ❑ No

How is your current physical/medical health, in general?
❑ Excellent ❑ Good ❑ Satisfactory ❑ Fair ❑ Poor

How would you rate your current nutrition and eating habits, in general?
❑ Excellent ❑ Good ❑ Satisfactory ❑ Fair ❑ Poor

On average, how many days do you exercise per week?
❑ None ❑ 1-2 days ❑ 3-4 days ❑ 5-6 day ❑ 7 days

How would you rate your current sleeping habits?
❑ Excellent ❑ Good ❑ Satisfactory ❑ Fair ❑ Poor

What medical problems/illnesses/symptoms do you have? ____

What are your current medications & doses? ____

On average, how many hours of sleep do you get per night? ______________________________________

Do you smoke cigarettes or chew and if so, how much per day? ___________________________________

Do you drink alcohol and if so, how much per day? ____

Do you use recreational drugs and if so, what, and how much per day? ___________________________

Have you ever received (or been encouraged to receive) alcohol/drug treatment? ❑ Yes ❑ No

Have you ever lived with anyone who was a problem drinker, alcoholic, or abused drugs? ❑ Yes ❑ No

Have you ever been prescribed psychiatric medication? If so, when and what medications? _________________
____

Please list any previously received mental health services (therapy, psychiatric services, dates of service): _____
____

Have you ever been hospitalized for mental health reasons? If so, when and what was the reason(s) for your hospitalization(s)? ____

Have you ever engaged in any self-harming behavior (cutting, scratching, burning, etc.)? If so, when and how? _
____

Have you ever attempted to take your own life? If so, when and how did you try? ________________________
____

Have you ever attempted to or succeeded in harming someone else? If so, when and how did you try? ________
____

Are you <u>currently</u> having thoughts of harming yourself or someone else? _______________________________

How was your childhood/growing up? ____
____

Growing up, were your parents separated or divorced? ❑ Yes ❑ No

Growing up, did you live with anyone who was depressed, mentally ill, or suicidal? ❑ Yes ❑ No

Growing up, did you live with anyone who used illegal street drugs or abused prescription medications? ❑ Yes ❑ No

Did you ever live with anyone who served time or was sentenced to time in a prison, jail, or other correctional facility?
❑ Yes ❑ No

Growing up, how often did your parents or adults in your home ever slap, hit, kick, punch or beat <u>each other</u> up?
❑ Never ❑ Once ❑ More than once ❑ Multiple times ❑ Don't know/remember

Growing up, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt <u>you</u> in any way? Do not include spanking.
❑ Never ❑ Once ❑ More than once ❑ Multiple times ❑ Don't know/remember

How often did a parent or adult in your home ever swear at you, insult you, or put you down?

❑ Never ❑ Once ❑ More than once ❑ Multiple times ❑ Don't know/remember

Please list any mental health and medical problems that run in your family (e.g., mother with depression): _____
____

Do you have any present-day distress in relationships with your parents/siblings/extended family? ___________
____

Do you have any present-day distress in your present-day close relationships (romantic, marital, friendship, etc.)? ____

How is your current level of accessible social support in your life?

❑ Excellent ❑ Good ❑ Satisfactory ❑ Fair ❑ Poor

Who is in your support system? ____

What is one of your strengths? ____

What is one of your limitations/areas for growth? _______________________________________

Please check if you are experiencing any of the following:

❑Depressed or sad mood ❑Feeling less joy in life or less interest in life ❑Thoughts of death/suicide
❑Fatigue/low energy ❑Weight/appetite change (gain or loss) ❑Decreased sexual desire
❑Too much or too little sleep ❑ Feel worthless or ashamed ❑Difficulty concentrating
❑Increased irritability ❑Feeling rested after 3-4 hours of sleep for many nights and not feeling tired
❑More talkative than usual ❑Increased sexual activity or promiscuity ❑Reckless behavior
❑Feeling powerful ❑Thoughts of harming someone else ❑None of these

Please check if you are experiencing any of the following:

❑Anxiety or panic attack ❑Worry that is difficult to stop ❑Trembling or shaking
❑Racing heart beat/pulse ❑ Felt anxiety was making you crazy ❑Fear of losing control
❑Fear of death or dying ❑Uncomfortable in social situations ❑Checking constantly
❑Worried about anxiety so much that it stopped you from leaving your home or going out
❑Thoughts in your mind that are hard to stop (obsessing) ❑Counting in your head
❑Repetitive hand washing, tapping, showering or activity you could not stop ❑None of these

Please check if you are experiencing or have experienced (<u>in childhood or adulthood</u>) any of the following:

❑Emotional Abuse ❑Physical Abuse ❑Sexual Abuse
❑Neglect ❑Unwanted Sexual Experience ❑Distressing dreams
❑Feeling out of body ❑Distressing memories of past events ❑Feeling things are not real
❑Losing big chunks of time ❑Attempts to block out or forget old memories ❑Have had painful or hard life experiences
❑Other: _______________ ❑None of these

Growing up, how often did anyone at least 5 years older than you or an adult, ever touch you (or try to touch you) sexually?

❑ Never ❑ Once ❑ More than once ❑ Multiple times ❑ Don't know/remember

Growing up, how often did anyone at least 5 years older than you or an adult, force you (or try to force you) to have sex?

❑ Never ❑ Once ❑ More than once ❑ Multiple times ❑ Don't know/remember

Please check if you are experiencing or have experienced any of the following:

❑Heard voices that others say might not be there
❑Seen images that others say might not be there
❑Strange smell that others do not smell
❑Strange tastes that do not make sense
❑Felt sensations on your body that do not make sense
❑Felt people are out to get you, harm you, follow you
❑Felt people are talking about you
❑Receiving unspoken messages from others
❑None of these

Please check if you are experiencing any of the following:

❑I am very concerned about my weight
❑I restrict my diet
❑I make myself vomit or use laxatives to control my weight
❑I sometimes binge on food
❑I spend hours every day working out to control my weight
❑I spend a lot of time thinking about my weight/body
❑ None of these

Please check if any of the following describe you:

❑I am very fearful of being alone or being abandoned
❑I feel like I am on an emotional roller coaster
❑I tend to build people up and then be disappointed
❑I can change my personality to fit the situation
❑Sometimes I am not sure who I am
❑I can be impulsive in ways that are harmful (sex, spending, driving, eating)
❑I tend to feel empty inside
❑I can get angry and have a temper
❑People sometimes call me arrogant
❑I find it difficult to understand what others feel
❑I am very concerned about power
❑I am special and sometimes people do not realize it
❑I find it difficult to follow social norms
❑I find it difficult to plan ahead
❑I sometimes get into physical fights
❑It is difficult for me to show remorse
❑I am superstitious
❑I have a sixth sense
❑I prefer solitary activities
❑I neither desire nor enjoy close relationships
❑I have limited but intense interest in only a few activities
❑I have difficulty making everyday decisions
❑I have a hard time initiating project on my own
❑I tend to be preoccupied with details and rules
❑I tend to be perfectionistic
❑Right is always right and wrong is always wrong
❑None of these

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

___

___

___

How were you referred to me:

❑ Self-Referred
❑ PsychologyToday.com
❑ Google/Web Search
❑ My Professional Website
❑ Insurance Referral
❑ Word of Mouth
❑ Referred by friend/family
❑ Referred by Physician
❑ Other: ___________

THANK YOU!