



Del Ray Psychological & Wellness Associates

Dr. Lauren Fisher, PsyD, PLLC

Dr. Eleni Boosalis, PsyD, PLLC

CLIENT INTAKE FORM

Name: _____

Date: _____

PRESENTING PROBLEMS

PRIMARY PROBLEMS

DURATION (months)

ADDITIONAL INFORMATION

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
depressed mood	[]	[]	[]	[]	bingeing/purging	[]	[]	[]	[]	guilt	[]	[]	[]	[]
appetite disturbance	[]	[]	[]	[]	laxative/diuretic abuse	[]	[]	[]	[]	elevated mood	[]	[]	[]	[]
sleep disturbance	[]	[]	[]	[]	anorexia	[]	[]	[]	[]	hyperactivity	[]	[]	[]	[]
elimination disturbance	[]	[]	[]	[]	paranoid ideation	[]	[]	[]	[]	dissociative states	[]	[]	[]	[]
fatigue/low energy	[]	[]	[]	[]	circumstantial symptoms	[]	[]	[]	[]	somatic complaints	[]	[]	[]	[]
psychomotor retardation	[]	[]	[]	[]	loose associations	[]	[]	[]	[]	self-mutilation	[]	[]	[]	[]
poor concentration	[]	[]	[]	[]	delusions	[]	[]	[]	[]	significant weight gain/loss	[]	[]	[]	[]
poor grooming	[]	[]	[]	[]	hallucinations	[]	[]	[]	[]	concomitant medical condition	[]	[]	[]	[]
mood swings	[]	[]	[]	[]	aggressive behaviors	[]	[]	[]	[]	emotional trauma victim	[]	[]	[]	[]
agitation	[]	[]	[]	[]	conduct problems	[]	[]	[]	[]	physical trauma victim	[]	[]	[]	[]
emotionality	[]	[]	[]	[]	oppositional behavior	[]	[]	[]	[]	sexual trauma victim	[]	[]	[]	[]
irritability	[]	[]	[]	[]	sexual dysfunction	[]	[]	[]	[]	emotional trauma perpetrator	[]	[]	[]	[]
generalized anxiety	[]	[]	[]	[]	grief	[]	[]	[]	[]	physical trauma perpetrator	[]	[]	[]	[]
panic attacks	[]	[]	[]	[]	hopelessness	[]	[]	[]	[]	sexual trauma perpetrator	[]	[]	[]	[]
phobias	[]	[]	[]	[]	social isolation	[]	[]	[]	[]	substance abuse	[]	[]	[]	[]
obsessions/compulsions	[]	[]	[]	[]	worthlessness	[]	[]	[]	[]	other (specify) _____	[]	[]	[]	[]

Are you currently experiencing any suicidal thoughts? If yes, please fill out:

Frequency of thoughts	When did thoughts begin?	Passive or Active?	Plans?	Attempts?	Please list prior ideation and/or suicide attempts with dates



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EMOTIONAL/PSYCHIATRIC HISTORY

Prior **outpatient** psychotherapy?

No Yes

Date(s)	Therapist/Facility	Reason for seeking treatment	Interventions	Beneficial?

Prior **inpatient** treatment for a psychiatric, emotional, or substance use disorder?

No Yes If yes, on _____ occasions. Longest treatment at _____ from ___/___/___ to ___/___/___

Name of facility _____ Month/Year _____ Month/Year _____

Inpatient facility name City/State _____ Diagnosis _____ Intervention/Modality _____ Beneficial? _____

Has any family member had inpatient or outpatient treatment for a psychiatric, emotional, or substance use disorder?

No Yes If yes, (list all): _____

Prior or current psychotropic medication usage? If yes:

No Yes

MEDICATION	DOSAGE	START DATE/END DATE	PHYSICIAN	SIDE EFFECTS	BENEFICIAL?

MEDICAL HISTORY

Describe current physical health: Good Fair Poor

List name of primary care physician:

Name _____ Phone _____

List name of psychiatrist: (if any):

Name _____ Phone _____

List any medications currently being taken (give dosage & reason):

List any known allergies: _____

Is there a history of any of the following in the family:

- tuberculosis heart disease
- birth defects high blood pressure
- emotional problems alcoholism
- behavior problems drug abuse
- thyroid problems diabetes
- cancer Alzheimer's disease/dementia
- mental retardation stroke
- other chronic or serious health problems _____

Describe any serious hospitalization or accidents:

Date _____ Age _____ Reason _____
Date _____ Age _____ Reason _____
Date: _____ Age _____ Reason _____



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FAMILY HISTORY

FAMILY OF ORIGIN

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[]	[]	[]
father	[]	[]	[]
stepmother	[]	[]	[]
stepfather	[]	[]	[]
brother(s)	[]	[]	[]
sister(s)	[]	[]	[]
other (specify)	[]	[]	[]

Parents' current marital status:

[] married to each other
 [] separated for ___ years
 [] divorced for ___ years
 [] mother remarried ___ times
 [] father remarried ___ times
 [] mother involved with someone
 [] father involved with someone
 [] mother deceased for ___ years
 age of patient at mother's death ___
 [] father deceased for ___ years
 age of patient at father's death ___

Describe parents:

Father	Mother
full name _____	_____
occupation _____	_____
education _____	_____
general health _____	_____

Describe childhood family experience:

[] outstanding home environment
 [] normal home environment
 [] chaotic home environment
 [] witnessed physical/verbal/sexual abuse toward others
 [] experienced physical/verbal/sexual abuse from others

Special circumstances in childhood: _____

IMMEDIATE FAMILY

Marital status: household:

[] single, never married
 [] engaged ___ months
 [] married for ___ years
 [] divorced for ___ years
 [] separated for ___ years
 [] divorce in process ___ months
 [] live-in for ___ years
 [] ___ prior marriages (self)
 [] ___ prior marriages (partner)

Intimate relationship:

[] never been in a serious relationship
 [] not currently in relationship
 [] currently in a serious relationship

Relationship satisfaction:

[] very satisfied with relationship
 [] satisfied with relationship
 [] somewhat satisfied with relationship
 [] dissatisfied with relationship
 [] very dissatisfied with relationship

List all persons currently living in patient's

Name	Age	Sex	Relationship to patient
_____	_____	_____	_____
_____	_____	_____	_____

List children not living in same household as patient:

_____	_____	_____	_____
_____	_____	_____	_____

Frequency of visitation of above: _____

Describe any past or current significant issues in intimate relationships: _____

Describe any past or current significant issues in other immediate family relationships: _____

SOCIO-ECONOMIC HISTORY

Living situation:

[] housing adequate
 [] homeless
 [] housing overcrowded
 [] dependent on others for housing
 [] housing dangerous/deteriorating
 [] living companions dysfunctional

Social support system:

[] supportive network
 [] few friends
 [] substance-use-based friends
 [] no friends
 [] distant from family of origin

Sexual history: (Optional)

[] heterosexual orientation [] currently sexually dissatisfied
 [] homosexual orientation [] age first sex experience _____
 [] bisexual orientation [] age first pregnancy/fatherhood ___
 [] currently sexually active [] history of promiscuity age ___ to ___
 [] currently sexually satisfied [] history of unsafe sex age ___ to ___

Additional information: _____



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DEVELOPMENTAL HISTORY (check all that apply for a child/adolescent patient or relevant childhood factors for an adult)

Problems during

mother's pregnancy:

- none
- high blood pressure
- kidney infection
- German measles
- emotional stress
- bleeding
- alcohol use
- drug use
- cigarette use
- other _____

Birth:

- normal delivery
- difficult delivery
- cesarean delivery
- complications _____
- birth weight ___lbs ___oz.

Infancy:

- feeding problems
- sleep problems
- toilet training problems

Childhood health:

- chickenpox (age _____)
- German measles (age ___)
- red measles (age _____)
- rheumatic fever (age ___)
- whooping cough (age ___)
- scarlet fever (age _____)
- autism
- ear infections
- allergies to _____
- significant injuries _____
- chronic, serious health problems _____
- lead poisoning (age _____)
- mumps (age _____)
- diphtheria (age _____)
- poliomyelitis (age _____)
- pneumonia (age _____)
- tuberculosis (age _____)
- mental retardation
- asthma

Delayed developmental milestones (check only those milestones that did not occur at expected age):

- sitting
- rolling over
- standing
- walking
- feeding self
- speaking words
- speaking sentences
- controlling bladder
- other _____
- controlling bowels
- sleeping alone
- dressing self
- engaging peers
- tolerating separation
- playing cooperatively
- riding tricycle
- riding bicycle

Emotional / behavior problems (check all that apply):

- drug use
- alcohol abuse
- chronic lying
- stealing
- violent temper
- fire-setting
- hyperactive
- animal cruelty
- assaults others
- disobedient
- repeats words of others
- not trustworthy
- hostile/angry mood
- indecisive
- immature
- bizarre behavior
- self-injurious threats
- frequently tearful
- frequently daydreams
- lack of attachment
- distrustful
- extreme worrier
- self-injurious acts
- impulsive
- easily distracted
- poor concentration
- often sad
- breaks things
- other _____

Social interaction (check all that apply):

- normal social interaction
- isolates self
- very shy
- dominates others
- alienates self
- associates with acting-out peers
- authority conflicts

Intellectual / academic functioning (check all that apply):

- normal intelligence
- mild retardation
- attention problems
- high intelligence
- moderate retardation
- learning problems
- underachieving
- severe retardation

Current or highest education level _____
 Current School _____

Describe any other developmental problems or issues: _____



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FINAL QUESTION(S):

What do you value most in life?

What are your personal strengths or positive personality attributes?

Where do you get your energy? What are you most passionate about?

What do you find works for you to release stress?

What do you hope to achieve during this therapeutic process? In your life (short-term/long-term)?

Is there anything else you would like me to know about you that may be important for this process?

Printed Name: _____ Signature: _____ Date _____