# CONFIDENTIAL INTAKE FORM

for

**Psychotherapy/Consultation Services**

by

**Janie L. Feldman, Psy.D.**

Please type or print neatly.

| | |
|---|---|
| Your Name | |
| Your Street Address | |
| Your City, State, Zip | |
| | |
| Your Preferred Phone Number | |
| Is this Cell, Home, Work or other? | |
| Other Phone (Cell, Home, Work?) | |
| Your Email Address | |
| Best Days and Times to Reach You | |
| | |
| Your Date of Birth | |
| Your Marital Status | |
| Name of Person You are Referring | |
| Your Relationship to this Person | |
| Date of Birth of this Person | |
| | |
| Grade and School (if applicable) | |
| Are You the Parent? Or Guardian? | |
| If Address is Different, Provide Street | |
| City, State, Zip | |
| | |
| Referral Source | |
| Is this a Friend or Professional Referral | |
| Area of Professional Specialization | |
| | |
| Person to Call in Case of Emergency | |
| Relationship to this Person | |
| Phone Numbers for this Person | |
| | |

Other family members residing with you include:

| Name | Age | Relationship to You |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

List any pets

| Name | Breed | Age | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

What services are you seeking? Check all that apply.

- ❑ Individual Psychotherapy
- ❑ Group Psychotherapy
  - Teen Friendship Group Therapy
  - Children's Friendship Group Therapy
  - Women's Group
  - Other Group: _____
- ❑ Family Therapy
- ❑ Couples' Therapy
- ❑ Assessment for ADHD, Learning Disabilities or Diagnoses
- ❑ Consultation to Physicians, Businesses, School Personnel or others
- ❑ Emergency Screening – **Bring this form with you.**

What issues concern you? Check all that apply.

- ❑ Anger Management
- ❑ Anxiety, Excessive Worrying or Insecurity
- ❑ Attention-Deficit/Hyperactivity Disorder (ADHD, ADD)
- ❑ Autism or Pervasive Developmental Disorders
- ❑ Behavioral Interventions
- ❑ Blending or Combining Families

- ❑ Body Image Issues and/or Disordered Eating
- ❑ Controlling Impulses, Acting without Thinking, Time Management Issues
- ❑ Depression, Feelings of Inadequacy, Hopelessness, or Low Self Esteem
- ❑ Difficulty Concentrating, Getting or Keeping Organized, Distractibility
- ❑ Effective Parenting through Behavior Modification and Reinforcement
- ❑ Feeling Empty, Unsatisfied, Disconnected, or Alone
- ❑ Gender Issues
- ❑ Identity Issues
- ❑ Impulsiveness or Control Issues
- ❑ Intense Emotionality or Difficulty with Emotion Regulation
- ❑ Irrational Fears or Phobias
- ❑ Low Motivation, Failure to Launch, Education and/or Career Stagnation
- ❑ Marital Conflict or Family Discord
- ❑ Men's Issues
- ❑ Obsessions and/or Compulsions (OCD)
- ❑ Oppositional, Defiant or Argumentative Behavior
- ❑ Overcoming Trauma
- ❑ Panic Attacks
- ❑ Parenting and Co-Parenting
- ❑ Relationship Difficulties, Separation, Reconciliation, or Divorce-related Issues
- ❑ Response Prevention Technique
- ❑ School or Learning Difficulties
- ❑ School Phobia/School Avoidance
- ❑ Self-Harming Behavior
- ❑ Separation Anxiety
- ❑ Sleep Difficulties (sleeping too much, too little or onset too late)
- ❑ Social Problems, Issues with Friends or Peers, Isolation or Harassment
- ❑ Stress Management
- ❑ Suicidal Thoughts or Feelings
- ❑ Unstable, Volatile or Destructive Relationships
- ❑ Unusual Changes in Mood, Excessive Moodiness, Rapid Mood Swings
- ❑ Women's Issues
- ❑ Work-related Stress
- ❑ Other. Please describe: _____

Please list all current medications, vitamins & supplements.

| Medication & Dosage | Purpose | Prescribing MD |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Do you/your child receive any other supportive services or other treatment (speech therapy, occupational therapy, coaching, tutoring, etc.? If so, please describe services below:

| Service | Provider | Frequency | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you seen a psychologist or therapist before? Please describe your experiences.

| Service Dates | Provider | Reason for Treatment | Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

In therapy, what do you hope to accomplish? Please write about your goal(s).

| |
|---|
| |
| |
| |
| |

Is there anything else Dr. Feldman should know? Please comment here.

| |
|---|
| |
| |
| |

My signature below confirms that the information provided in this form is complete and accurate, to the best of my knowledge.

_____ _____

Signature of Patient, Parent or Guardian Date

_____

Relationship to Prospective Patient/Client