NASSAU PSYCHOLOGY P.C.

Nassau Psychology P.C.

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1. Intake Form

Client Full Name:

What is the reason you are seeking therapy?:

I have problems in the following areas:

- [ ] Marriage/Relationship/Family
- [ ] Friendship/Peer Relationships
- [ ] Job/School Performance
- [ ] Physical Health
- [ ] Eating Habits/Bingeing/Purging/Starvi
- [ ] Sexual Functioning/Gender Issues
- [ ] Ability to Concentrate/Distractibility/Attention Span
- [ ] Ability to Control Temper
- [ ] Strange Thoughts/Strange Experiences
- [ ] Repetitive Behaviors / Obsessions / Compulsions
- [ ] Hyperactivity/Tics
- [ ] Memory
- [ ] Impulse Control / Stealing / Hair Pulling / Gambling

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression

- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Relationship concern
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Are you currently being prescribed any medications for a mental health condition? If yes, please provide the following: Prescribers Name, Address, & Phone Number/Fax:

Please list Current medications:

Please list Previous diagnoses/mental health treatment:

Do you have any history of trauma?:

Do you currently have suicidal thoughts?:

Suicide & Crisis Lifeline: If your life or someone else's is in imminent danger, please call 911. If you are in crisis and need immediate help, please call: 988

Family History

Were there any traumatic or difficult times/events during childhood/adolescence, growing up?:

Family member psychiatric conditions:

Present Situation

Work:

- [ ] Married
- [ ] Divorce
- [ ] Single

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and what were the charges?:

Do you currently or have you ever had CPS/APS involvement? If yes, when and what were the allegations?:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuanna
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)
- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

List current illicit drug use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Have you ever abused prescription drugs? If yes, which ones?:

For Marriage/Couples Counseling

Spouse's Current medications? Previous medications?:

Has your spouse been treated for any psychiatric conditions? If yes, which ones?:

List Spouse's current illicit drug use:

Has your spouse ever been treated for drug/alcohol abuse? If yes, when?:

Primary Care Physician

It is very important that I communicate with your primary care physician and your psychiatrist (if you have one) after your consultation. Please take a few moments to provide your doctor's contact information.

Name, Phone Number, Fax Number, Address:

Additional

Are you or your significant other seeing another therapist in our practice:

Anything else you would like your therapist to know?:

Emergency Contact

Please enter the name, relationship, and phone number your therapist should call in the case of an emergency.

Name:

Relationship to client:

Phone Number: