

# Hollywood Psychology Center

3595 Sheridan St., Suite 103, Hollywood, FL 33021  
Tel: 954-981-8200 Fax: 954-272-8043  
www.HollywoodPsychologyCenter.com

## Confidential Client Intake Information Questionnaire

■ Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Other phones \_\_\_\_\_

Is it OK to contact you on these #'s  No  Yes If no, how can I contact you? \_\_\_\_\_

E-mail address \_\_\_\_\_

■ Birthplace \_\_\_\_\_ Marital status \_\_\_\_\_

# of times married \_\_\_\_\_ # years in current marriage \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Education \_\_\_\_\_

■ Spouse's name \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

How many children do you have?

Name _____	Age _____	Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes
Name _____	Age _____	Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes
Name _____	Age _____	Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes
Name _____	Age _____	Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes
Name _____	Age _____	Currently living with you <input type="checkbox"/> No <input type="checkbox"/> Yes

■ Religion/Ethnicity/Gender issues of note \_\_\_\_\_

■ Who referred you \_\_\_\_\_

Family doctor \_\_\_\_\_

List any major health problems \_\_\_\_\_

Please list any medications you take \_\_\_\_\_

Have you been in therapy before?  No  Yes

If yes, when? For what issues? \_\_\_\_\_

Whom did you see? Did it help? (explain) \_\_\_\_\_

\_\_\_\_\_

Please check any of the following that are currently troubling you:

- inferiority feelings
- suicidal thoughts
- making decisions
- health problems
- stomach trouble
- career choices
- concentration
- being a parent
- painful thoughts
- drug use/abuse
- children
- shyness
- separation
- anger
- sleep
- relaxation
- energy
- legal matters
- marriage
- nervousness
- loneliness
- education
- guilt
- bowel trouble
- depression
- divorce
- alcohol use
- compulsions
- self-control
- ambition
- headaches
- insomnia
- agoraphobia
- appetite
- fears
- finances
- friends
- confidence
- unhappiness
- stress
- phobias
- extreme fatigue
- panic attacks
- overweight
- sexual abuse
- abused as a child
- temper
- ACOA
- work
- tiredness
- sadness
- sexual problems
- fetishes
- conflict
- self-esteem
- homicidal
- no interests
- impotence

At any time in your life, have you thought about hurting or killing yourself?  No  Yes

Did these thoughts include a plan and serious intent? If so, when and what were some of the details?

---

---

Please describe briefly your reasons for seeking psychological consultation or therapy

---

---

What do you hope to get out of this consultation

---

---

Is there any more information that you think is important for me to know

---

---

Please be aware that **cash or checks** are the only form of payment accepted by the office. Full payment is expected at the time of your visit. If you have health insurance that covers psychological treatment please discuss this with the office staff to inquire about coverage and fill out the required forms. We generally operate very much on time so please be prompt for your appointment or your appointment may be cut short due to starting late.

Since your appointment time is reserved **exclusively for you**, or cancellation policy is as follows:

**Appointments must be canceled 24 hours in advance. Appointments which are not given a 24 hour notice and/or missed appointments without cancellation will be subject to the full fee, as if the appointment was kept. Since insurance companies do not pay for missed appointments, this fee is the sole responsibility of the person responsible for payment, and cannot be billed to your insurance. Thank you for your cooperation.**

Signature of Responsible Party

SSN

---

**For clinical use only**

Diagnosis

---

---

---