Hollywood Psychology Center

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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 ☐ No ☐ Yes

Name Age Currently living with you ☐ No ☐ Yes

Name Age Currently living with you ☐ No ☐ Yes

Name Age Currently living with you ☐ No ☐ Yes

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

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