

Hollywood Psychology Center

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Confidential Client Intake Information Questionnaire

■ Therapist's name _____ Lic # _____ Date _____

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
- 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
- battered/beaten
- 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

■ YOUR signature

SSN

Please be aware that we operate on a "cash or check" basis. That is, we expect FULL payment at the time of each visit. If you have health insurance that covers psychological treatment please discuss this with the receptionist or doctor to inquire about coverage and fill out the required forms. I generally operate very much on time so please arrive on time for your appointment. Your appointment time is reserved exclusively for you, and thus we do charge for not cancelled (24 hrs. prior) or missed appointments. If you have questions about financial arrangements please bring them up. Thanks!

■ **For clinical use only**

Diagnosis
