Please print and fill out this form. Bring to your first appointment. Thank you.

PATIENT INFORMATION DATE______________

IF PATIENT IS AN ADULT, PLEASE COMPLETE:

Patient Name:____

Address:____
Street City State Zip

Phone:____
Home Cell

Date of Birth: __________________ EducationalLevel:__________________________

Occupation:______________________________Gender: Male_____Female________

Spouse
Name:____

Children's name and ages____

Marital Status: Single______ Married______ Divorced ______

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Patient Name:____

Address:____
Street City State Zip

Phone: Home_________________________Cell___________________

Date of Birth:__________________School:_______________________Grade:_______

Father's Name:____

Address:____
Street City State Zip

Phone: Home_________________________Cell______________________________

Mother's Name:____

Address:____

Street City State Zip

Phone: Home_______________________Cell___________________________

Both parents must agree to treatment of minor

MEDICAL HISTORY:

Significant Illnesses, Physical Conditions, Hospitalizations (include dates):

____

____

Medications currently using:____

____or provide list

Whom were you referred by: ____

I hereby authorize the release of medical information necessary to process my claims and I authorize payment of medical benefits to Dr Pamela Rebeck and understand that I am responsible for charges not covered by my insurance.

Also my signature indicates that I agree to the HIPPA Psychotherapist-Patient Services Agreement which is available on my website. If you want a copy, please download.

____

Patient Signature Printed Name Date

____

Responsible Party's Signature Printed Name Date

Patients 12 years old and above

Client Name______________________________Date__________

INITIAL INTAKE QUESTIONAIRE

1. What is your main reason for seeking counseling at this time?

2. List several goals you would like to achieve through counseling:

A.
B.
C.
D.

3. Please describe any significant problems or stressors you are experiencing and for how long:

   a. Mental or Emotional:

   b. Family Relationships

   c. Work or School:

   d. Health:

   e. Legal Concerns

   f. Financial Pressures:

4. How would you rate your use of alcohol or drugs? List substances and how often.

5. Do you suspect you *misuse* any prescription medications?

6. Are you concerned about your physical safety? Please explain.

7. Please rate the following areas in your life –

"S" for areas you are **S**atisfied with or a **"D"** for areas you are **D**issatisfied with:

__ Housing/Living Situation
__ Employment/Work Situation
__ Family Support
__ Education
__ Spouse/Partner Support
__ Relationships With Friends
__ Ability to Care for Yourself
__ Financial Situation

7. **FAMILY HISTORY**: Please check the following problems that have occurred and note if occurred in: **a)** your immediate family, **b)** the family you grew up in, **c)** other relatives, or **d)** yourself.

☐ Substance abuse (alcoholism, drug abuse)	☐ Family "secrets"
☐ Other addictions	☐ Infidelity
☐ Sexual abuse	☐ Chronic lying
☐ Physical abuse	☐ Children out of wedlock
☐ Mental or emotional abuse	☐ Abortion
☐ Depression	☐ Divorce
☐ Suicide or attempted suicide	☐ Religious abuse
☐ Mental Illness	☐ Eating Disorders

8. What physical, mental or emotional **SYMPTOMS** have you experienced recently? Check all that apply.

☐ Muscle twitches	☐ Wish You Could Go To Sleep and Never Wake Up
☐ Decrease in energy or Fatigue	☐ Impaired Memory (forget things more than usual)
☐ Hyperactivity	☐ Racing Thoughts or Speech
☐ Impulsiveness	☐ Tendency to go off on tangents
☐ Sexual Problems	☐ Difficulty speaking
☐ Restlessness	☐ Racing Heart
☐ Problems at work, school or academics	☐ Anxiety
☐ Over-aggressiveness	☐ Fear of abandonment
☐ Withdrawn from family or friends	☐ Panic Attacks
☐ Stealing or Dishonesty	☐ Excessive Worry
☐ Destructiveness	☐ Flashbacks of Distressing Events
☐ Disorganization	☐ Phobias or Excessive Fears
☐ Trouble with Authority Figures	☐ Afraid of Open Spaces
☐ Breaking Rules, Pushing Limits	☐ Nervousness
☐ Injuring Self (such as cutting, pulling hair, etc.)	☐ Unsure of What is Real
☐ Trouble with Sleep (too much, too little, insomnia, etc.)	☐ Feel Like You are Outside Your Body Watching Self
☐ Anger or Hostility	☐ Sometimes Think You Are Hallucinating
☐ Apathy	☐ Obsessions, Trouble Getting Thoughts Out of Mind
☐ Depressed Mood or lingering sadness	☐ Excessive Fears of ________________
☐ Crying Spells or Tears Come Easily	☐ Concerns Others Are Spying or Trying to Poison You
☐ Emotional Highs	☐ Suicidal Thoughts or Wishes
☐ Feeling Guilty	☐ Murderous Thoughts or Wishes
☐ Helplessness	☐ Eating Disorder (starving, binging or purging)
☐ Hopelessness	☐ Emotional eating
☐ Irritability	☐ Unable to Maintain Normal Weight
☐ Feelings of rejection	☐ Dissatisfied With Body Shape or Weight
☐ Low Self-Esteem	☐ Concern Over Your Use of Alcohol
☐ Reduced Interest or Enjoyment in Life	☐ Concern Over Your Use of Drugs
☐ Noticeable Mood Swings	☐ Persistent Desire for Alcohol or Drugs
☐ Difficulty Thinking or Concentrating	☐ Chronic Pain
☐ Easily Distracted	☐ Medical Conditions:
☐ Difficulty Making Decisions	

9. **List all medications you are taking as well as the dosages and the condition being treated:**

MEDICATION	CONDITION	DOSE	How Often	When Started