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New Client Adult Intake Form

Today's Date: _____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: ____/____/____ Age: _____ Gender: Male Female

Ethnicity: Asian Hispanic / Latino African-American Caucasian Other: _____

RELATIONSHIP STATUS:

Single Partnered / Significant Other Married Separated Divorced Widowed

Duration of Relationship: _____ Number of Children: _____ Children Still Residing in the Home: _____

STUDENT / EMPLOYMENT STATUS:

Full-Time Employed Part-Time Employed Homemaker / Caretaker Legally Disabled

Unemployed Retired Full-Time Student Part-Time Student

Length of Employment: _____ Retirement / Unemployment Date: _____

School and Major / Degree: _____

Employer Name and Position: _____

PHYSICIAN INFORMATION:

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Care Physician (PCP): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION:

Mailing Address:

Physical Address (If Different):

May I send mail to the above mailing address? Yes No

Telephone Numbers / Email Address (Please provide only numbers at which you give me permission to call you):

Home: _____
Work: _____
Cell: _____
Email*: _____

May I leave a message? Yes No
May I leave a message? Yes No
May I leave a message? Yes No
May I email you? Yes No

*Please be aware that email might not be confidential.

Contact person in case of emergency: _____

Telephone #: _____ **Relationship:** _____

MENTAL HEALTH HISTORY:

1. Are you currently receiving psychotherapy elsewhere? Yes No
2. Have you ever had psychotherapy in the past? Yes No
3. If yes, previous therapist's name to either question above: _____
When? _____ Duration of treatment: _____
Focus of treatment / presenting issue: _____
4. May I contact your primary care / referring physician to coordinate care? Yes No
5. In the past year, have you experienced any significant life changes, stressors, loss / grief, crisis, or trauma? Yes No
If yes, please describe: _____
6. Have you ever experienced or are currently experiencing any of the following? Yes No
 - Depression / feeling down / apathy
 - Bipolar disorder / extreme mood swings
 - Anxiety disorder / panic attacks (most recent occurrence): _____
 - Phobias (phobia triggers): _____
 - Sleep disturbance (e.g., difficulty falling or staying asleep, sleeping too much / too little, restlessness, etc.)
 - Schizophrenia / hallucinations (auditory / visual)
 - Unexplained memory lapses
 - Alcohol / prescription medication / recreational drug abuse
 - Frequent body complaints (e.g., achiness, persistent pain, migraine / tension headaches)
 - Eating disorder (previous or current treatment): _____
 - Body image issues
 - Repetitive thoughts or behaviors (e.g., obsessions, rituals, etc.)
 - Problems with concentration, focus, learning disability
 - Trauma history / crisis
 - Homicidal thoughts / acts of aggression
 - Suicidal thoughts / attempts (last attempt / hospitalization): _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family experienced difficulties with any of the following? Yes No

- Depression
- Bipolar disorder / extreme mood swings
- Anxiety disorder / pain attacks
- Phobias (phobia triggers): _____
- Sleep disturbance (e.g., difficulty falling or staying asleep, sleeping too much / too little, restlessness, etc.)
- Schizophrenia / hallucinations (auditory / visual)
- Unexplained memory lapses
- Alcohol / prescription medication / recreational drug abuse
- Frequent body complaints (e.g., achiness, persistent pain, migraine / tension headaches)
- Eating disorder
- Body image issues
- Repetitive thoughts or behaviors (e.g., obsessions, rituals, etc.)
- Problems with concentration, focus, learning disability
- Trauma history / crisis
- Homicidal thoughts / acts of aggression
- Suicide attempts / completion (family member): _____

REASON FOR SEEKING COUNSELING / BIOFEEDBACK:

What is the reason you are seeking counseling or biofeedback?

What would you like to gain from counseling or biofeedback? What are your goals?

What activities / roles / responsibilities do you hope to resume or participate more in?

MEDICAL AND HEALTH HISTORY

Name: _____

Date: _____

1. Where is your pain located / medical diagnosis? _____

2. How did your pain / medical condition start?

- After a work related injury Date: _____ Workman’s comp? Yes No
- After an auto accident Date: _____ Pending litigation? Yes No
- After an injury Date: _____ Pending litigation? Yes No
- Developed slowly over time
- Other: _____

3. Please check the kinds of doctors or specialists you have seen about your pain / medical condition:

- Orthopedic Internal medicine
- Neurologist General surgeon
- Neurosurgeon Oncologist
- Physical medicine Hand surgeon
- Gynecologist Psychiatrist
- Pain management / anesthesiologist Plastic surgeon
- Cardiologist Urologist
- Dermatologist Rheumatologist
- Endocrinologist Other: _____
- Gastroenterologist

4. What tests have been done to try to diagnose your pain / medical condition?

- X-rays Bone Scan
- MRI scan Blood work
- CT scan Ultrasound
- Myelogram Other: _____

Findings: (if known): _____

5. What other treatments have you tried to help this pain?

- Physical therapy Biofeedback
- TENS unit Hypnosis
- Injections or nerve blocks Acupuncture
- Stress management Chiropractic
- Interdisciplinary pain program Other: _____

6. Do you regularly participate in any of the following?

- Cardio exercise / stretching / strengthening Relaxation / biofeedback exercises
- Massage Self-hypnosis
- Tai Chi Other: _____

7. Please check either “Yes” or “No” to any of these which apply to you:

	Yes	No
Do you consume a lot of caffeine daily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently drink alcohol on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
Currently under a lot of stress?	<input type="checkbox"/>	<input type="checkbox"/>
Current family problems?	<input type="checkbox"/>	<input type="checkbox"/>

8. Please check and circle all that currently apply:

- Irritability / quick temper / mood swings
- Nervousness / restlessness (daytime / nighttime)
- Insomnia / frequent waking / too much sleep
- Disturbing dreams / nightmares
- Daytime drowsiness
- Sedation from prescription medication
- Migraine / tension headaches
- Lightheadedness / dizziness
- Poor focus / concentration
- Confusion / disorientation
- Poor memory / forgetfulness
- Trouble working / loss of productivity
- Difficulty driving
- Increased / decreased appetite
- Unplanned weight loss / gain
- Bowel / bladder problems, incontinence, or pain
- Abdominal pain / constipation / diarrhea / IBS
- Nausea / vomiting
- Difficulty breathing / asthma / lung pain
- Chest pain / tightness
- Abnormal heart beat / arrhythmia
- Rash / eczema / psoriasis / easy bruising
- Muscle weakness / fatigue
- Numbness / tingling sensation / nerve pain
- Decreased sexual interest
- Other: _____

DAILY LIFE QUESTIONNAIRE

1. In general, would you say your overall health is?

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, rate each one using the following scale.

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, riding a bike, playing golf, etc.

1. Yes, limited a lot 2. Yes, limited a little 3. No, not at all

3. Climbing several flights of stairs.

1. Yes, limited a lot 2. Yes, limited a little 3. No, not at all

During the past 4 weeks have you had any one of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like? 1. Yes 2. No

5. Were limited in the kind of work or other activities? 1. Yes 2. No

Overall during the past 4 weeks have you had any of the following problems with your work or other regularly daily activities as a result of any emotional problems (such as feeling anxious or tense?)

6. Accomplished less than you would like? 1. Yes 2. No

7. Did not do work as carefully as usual? 1. Yes 2. No

8. Overall, during the past 4 weeks how much did pain interfere with your normal work (including both inside and outside the home and housework):

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Now please rate how things have been during the past 4 weeks. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

1. All 2. Most 3. A good bit 4. A little 5. None
.....OF THE TIME.....

9. Have you felt calm and peaceful?

10. Did you have a lot of energy?

11. Have you felt downhearted and blue?

12. During the past 4 weeks, how much of the time has your physical or emotional problems interfered with your social activities (e.g., visiting with friends, relatives, etc).

1. All of the time 2. Most of the time 3. A good bit of the time 4. A little 5. None

COPING TECHNIQUES FOR MANAGING PAIN / MEDICAL CONDITION

In the last 7 days on how many days did you do the following to manage your pain / medical condition?

- 1. Distract self by getting active in something else 1 2 3 4 5 6 7
- 2. Relaxation tapes, self-hypnosis, biofeedback for at least 15 minutes 1 2 3 4 5 6 7
- 3. Stretching program (at least for 10 minutes) 1 2 3 4 5 6 7
- 4. Exercise (for at least 30 minutes, e.g., walking, back strengthening) 1 2 3 4 5 6 7

5. How helpful were these or other techniques (other than medicine) in managing your pain?

Not helpful

Very helpful

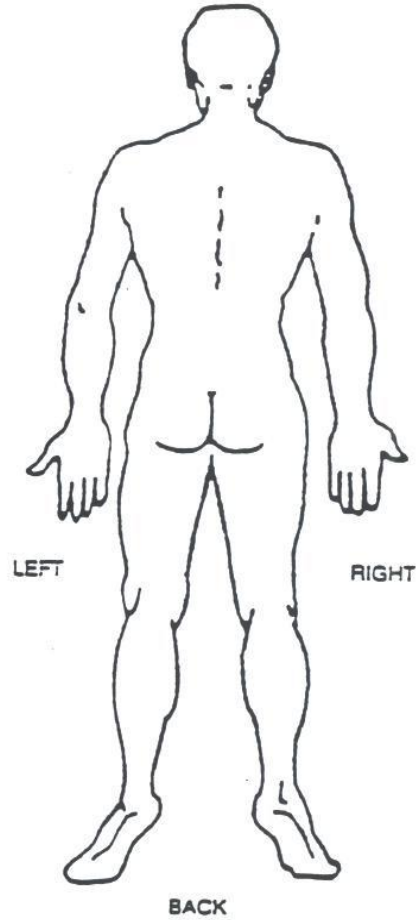
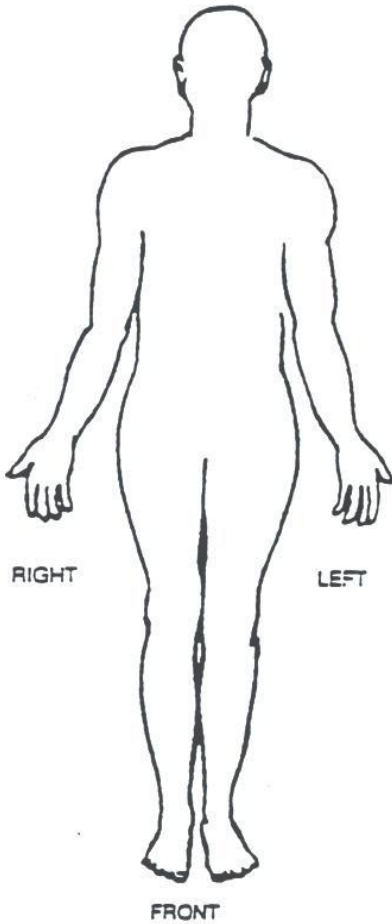
1 2 3 4 5 6 7 8 9 10

BODY MAP / SITES OF DISCOMFORT

Mark the area on your body where you feel the described sensations:

^^^^^ Aching
OOOO Numbness
----- Pins & Needles

XXXX Burning
//////// Stabbing



On a scale of 0 to 10, please circle how intense your pain or discomfort is at the present moment.

0----1----2----3----4----5----6----7----8----9----10

Date of last complete physical: _____

How many times in the past 12 months have you visited the ER / ED for your pain or medical problem? _____

INSURANCE INFORMATION / AUTHORIZATION OF PAYMENT OF SERVICES

Insurance Information:

Insurance Plan Name: _____

Insured Name: _____ Insured ID Number: _____

Insured's Social Security Number: _____

Co-Payment: _____ Deductible Amount: _____

Driver's License Number: _____ State Issued: _____

Please remember that I will be considered an out-of-network provider should you wish to use your insurance for reimbursement of payment for services.

Credit Card Information and Authorization for Payment:

I, _____, authorize Katherine E. Walker, PhD, LPC, NCC, BCIA-C to charge the below-referenced credit card when I have not cancelled my scheduled appointment within 24 hours. I understand that this also includes any appointment that is considered a client no-show or for any balance due that is owed due to my insurance company not covering services.

Type of Card:

MASTERCARD

VISA

DISCOVER

Account Holder Name Listed on Credit Card: _____

Credit Card Number (Please Include Dashes): _____

Credit Card Expiration Date: _____

Three (3) Digit Security Code for Credit Card: _____

Complete Billing Address for This Credit Card:

Authorized Card Holder Signature

Date