LAURA ESPINOSA, PLLC

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LICENSED CLINICAL PSYCHOLOGIST

INTAKE FORM

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session

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

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Marital Status:
□ Single □ Married □ Domestic Partnership □ Divorced □ Widowed

Name and age of significant other: _____

How long have you been in this relationship? _____

What is your level of commitment to this relationship (1-low, 10- high) _____

Please list any children/age: _____

How many times have you been pregnant?_____

E-mail: _____ May we email you? □ Yes □ No
*Note: Email correspondence is **not** considered to be a confidential medium of communication.

Referred by (if any): _____

Emergency Contact:

_____ _____
(Name) (Phone)

In your own words, what is the presenting problem? When did your problem begin? How is it affecting your daily functioning? Please include symptoms, frequency, duration, intensity, and triggers.

_____
_____
_____
_____

History of trauma in your lifetime, or recent crisis (last five years)

_____

History of abuse (emotional, verbal, physical, or sexual), past or present.

_____

Are you at risk of killing/ hurting yourself or others? □ No □ Yes

In the past, have you thought of killing/ hurting yourself or others? □ No □ Yes

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes _____

What do you do for fun and relaxation?_____

_____

What supportive relationships do you have in your life?_____

_____

Do you have frequent arguments with others, or do you have impulsive reactions? _____

_____

What are your needs, preferences, and goals regarding your treatment? _____

_____
_____
_____

Have you ever been prescribed psychiatric medication?

□ No

□ Yes Please list and provide dates: _____

_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Please list any specific health problems you are currently experiencing:
_____
_____

Are you currently taking any prescription medication?
□ No
□ Yes Please list: _____
_____
_____

2. Are you currently experiencing any specific sleep problems?_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in? _____

4. Do you smoke? If so, how much? _____

5. How much caffeine do you consume in a day? _____

6. Are you experiencing any difficulties with your appetite or eating patterns?_____
_____

Do you make yourself throw up or work out excessively to lose weight? □ No □ Yes

7. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long? _____

8. Are you sleeping too much, lacking motivation, or have problems concentrating? □ No □ Yes

9. Are you currently experiencing anxiety, panic attacks, excessive worries, or phobias?
□ No □ Yes
If yes, when did you begin experiencing this? _____

10. How often you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

11. Do you engage in recreational drug use? □ No □ Yes

12. What significant life changes or stressful events have you experienced recently?
_____
_____
_____

FAMILY OF ORIGIN MENTAL HEALTH HISTORY:

Number of siblings and quality of relationship with siblings and parents. History of parental divorce/ abandonment.

_____

_____

Please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, sister, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Alzheimers Disease	yes/no	

EDUCATIONAL/ OCCUPATIONAL, AND ADDITIONAL INFORMATION:

High School completed? Name of School _____

College attended_____

Degree earned/ Major _____

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

Signature _____ Date _____