

CLIENT INTAKE FORM

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Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:

- Medical Provider: _____
- Insurance Provider: _____
- My Website:
- PsychologyToday
- Friend/Family: _____
- Other: _____

Have you previously received any type of mental health services?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of provider or facility: _____

Location: _____

Dates of treatment: _____

Reason for treatment: _____

Briefly, what brings you in today

When did your problem first start? Within the last:

- 30 days
- 6--12 months
- 2 years
- During adolescence
- During childhood

What areas of your life have been affected because of this problem?

Are you currently experiencing overwhelming sadness, grief or depression?

- Yes
- No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias?

Yes

No

If yes, when did you begin experiencing this? _____

Please describe any major losses or traumas you have experienced:

Have you ever suffered any Physical, Emotional, Verbal or Sexual Abuse? If Yes. Please explain:

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

What would you like to accomplish out of your time in therapy?

Current Symptoms

Please Check All That Apply:

- | | |
|--|--|
| <input type="checkbox"/> Loss of Interest or Pleasure | <input type="checkbox"/> Low Self Esteem |
| <input type="checkbox"/> Friends (Making, Keeping, Choosing) | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Low Energy | <input type="checkbox"/> Relationship Problems |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Difficulty Saying No |
| <input type="checkbox"/> Communication Problem | <input type="checkbox"/> Sense of Inferiority |
| <input type="checkbox"/> Hopelessness/Helplessness | <input type="checkbox"/> Fear of Rejection |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Fear of Being Alone |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Sexually Acting Out |
| <input type="checkbox"/> Persistent Guilt | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Irritable/ Easily Annoyed | <input type="checkbox"/> Impatient |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Easily Frustrated |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Easily Distracted |
| <input type="checkbox"/> Excessive & Persistent Worry | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Anger Issues | <input type="checkbox"/> Career Problems |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> High Risk Behavior | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Weight Loss |
| | <input type="checkbox"/> Body Image Issues |

Family History

Where were you born? _____

Where did you grow up? _____

- City
- Suburbs
- Country

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	Where do they live now?	If deceased, age and cause of death

Who did you live with while growing up? _____

Mother's occupation: _____

Father's occupation? _____

In the section below 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, grandmother, uncle, etc.)

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or Fax: _____

How would you rate your current physical health?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits?

- Poor
- Unsatisfactory
- Satisfactory
- Good
- Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- Falling asleep
- Staying asleep
- Awakening early
- Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

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

Are you currently experiencing any chronic pain?

No

Yes

If yes, please describe:

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Additional Information

What do you enjoy about your work (full-time homemaker included)? If retired, what did you enjoy about your work?

What do you find particularly stressful about your current or previous work?

What do you enjoy doing in your free time? What do you do to relax?

Do you consider yourself to be spiritual or religious? If yes, please describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?