

# PLEASE COMPLETE THE ATTACHED INTAKE CONSULTATION FORM

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NAME

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APPOINTMENT DATE AND TIME

## NOTICE

Please be aware that insurance companies and other agencies may request copies of this intake form, as well as written session notes from our office, in order for your insurance benefits to be paid. If you **do not** wish this information to be released please see *Page 10*. You will also be asked to sign another release form prior to your initial visit.

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Date: \_\_\_\_\_

Interviewer: \_\_\_\_\_

Referred By: \_\_\_\_\_

Allergies, i.e., medications: \_\_\_\_\_

1. Name: \_\_\_\_\_ Male / Female Birth Date \_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_ - \_\_\_ - \_\_\_

2. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Office) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Email) \_\_\_\_\_

3. Employer \_\_\_\_\_ Occupation \_\_\_\_\_

4. Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

5. Marital Status \_\_\_\_\_ Years Married \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Right / Left Handed

6. Spouse's Name \_\_\_\_\_ Birth Date \_\_\_ / \_\_\_ / \_\_\_ SS# \_\_\_ - \_\_\_ - \_\_\_

7. Spouse's Employer/Address \_\_\_\_\_ Phone \_\_\_\_\_

8. Parents (**Father**) \_\_\_\_\_ (Age) \_\_\_\_\_ (**Mother**) \_\_\_\_\_ (Age) \_\_\_\_\_

9. Children \_\_\_\_\_ Sex (M) \_\_\_\_\_ (F) \_\_\_\_\_ Location \_\_\_\_\_

10. Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Location \_\_\_\_\_

11. Person to contact in emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ Address \_\_\_\_\_

12. Hobbies \_\_\_\_\_

*(How do you spend your free time?)*

13. Physical exercise \_\_\_\_\_

*(Amount/type & frequency)*

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Do you have any of these common symptoms? Please note their intensity and frequency. Please include all symptoms, even if you consider them unimportant.

Range: From none (0) to overwhelming (10) – (e.g., 3 – 7)

Frequency: Times a Day (D), Week (W), Month (M), or Year (Y) – (e.g., 3 x D)

<b>PHYSICAL SYMPTOMS</b> <b>Circle Symptom</b>	<b>RANGE OF INTENSITY</b>	<b>FREQUENCY OF OCCURRENCE</b>
1. Cold hands or feet _____		
2. Hot or cold spells _____		
3. Headaches _____		
4. Neck, shoulder, back or other muscle pain _____		
5. Pains or tightness in chest or heart _____		
6. Frequent illness _____		
7. Sweating hands, feet, etc. _____		
8. High or low blood pressure _____		
9. Nausea, vomiting, upset stomach _____		
10. Diarrhea, constipation _____		
11. Stomach aches, abdominal pains _____		
12. Heart pounding, racing, arrhythmias _____		
13. Muscle twitches or tremors _____		
14. Nervousness, shakiness, trembling, tremors _____		
15. Coronary heart disease _____		
16. Easily fatigued, low energy, burnout _____		
17. Premenstrual syndrome (PMS) _____		
18. Pain or sensitivity to light or noise _____		
19. Dizziness or vertigo or faintness _____		
20. Coordination problems _____		
21. Itching, skin disorders _____		
22. Dry throat or mouth _____		
23. Teeth grinding or clenching _____		
24. Frequent urination _____		
25. Accident, injury prone _____		
26. Trouble getting your breath _____		
27. Body numbness or tingling _____		
28. A lump in your throat _____		
29. Weakness or heaviness of body _____		
30. Eating disorders, loss or increase of appetite _____		
31. Loss or excessive interest in sex _____		
32. Other pain _____		

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**BEHAVIORAL/EXPERIENTIAL SYMPTOMS**  
**Circle Symptom**

**RANGE OF  
 INTENSITY**

**FREQUENCY OF  
 OCCURRENCE**

33.	Nail biting _____		
34.	Having trouble falling or staying asleep _____		
35.	Unable to get rid of negative thoughts/ideas _____		
36.	Unusual body feelings _____		
37.	Anxiety, fear, apprehension, panic _____		
38.	Feeling critical of others _____		
39.	Nightmares _____		
40.	Stuttering, stammering, etc. _____		
41.	Trouble remembering things, mind goes blank _____		
42.	Worried about sloppiness _____		
43.	Feeling easily annoyed, angered, irritated _____		
44.	Feeling confused _____		
45.	Crying easily _____		
46.	Temper outbursts you cannot control _____		
47.	Blaming yourself for things _____		
48.	Impulsive behavior, emotional instability _____		
49.	Fidgety, restless, antsy, impatient _____		
50.	Feeling blocked in finishing tasks _____		
51.	Feeling lonely, separate, sad _____		
52.	Substance abuse – food, alcohol, drugs _____		
53.	Worry, concern, feeling serious _____		
54.	Feeling no interest in things _____		
55.	Feeling guilty, shame _____		
56.	Feelings being easily hurt _____		
57.	Feeling others are not sympathetic _____		
58.	Doing things slowly to be sure they are right _____		
59.	Feeling inferior to others _____		
60.	Having to double check what you do _____		
61.	Difficulty making decisions _____		
62.	Wanting to be alone _____		
63.	Trouble concentrating, distracted _____		
64.	Mood swings _____		
65.	Feeling hopeless about the future _____		
66.	Feelings of unreality / unusual mental events _____		
67.	Depression, withdrawal, procrastination, resistance _____		
68.	Feeling self-conscious _____		
69.	Talking too much _____		
70.	Feeling you are watched or talked about by others _____		
71.	Feeling people are unfriendly or dislike you _____		
72.	Feeling others are to blame for your troubles _____		
73.	Feeling people will take advantage if you let them _____		
74.	Feeling something is wrong with your mind _____		
75.	Lack of motivation, interest _____		
76.	Reduction in accuracy, productivity _____		
77.	Sexual shyness – disorders _____		

**If you exhibit more than a few of these symptoms, you are experiencing the effects of stress and would benefit from learning to reduce stress and pain.**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**MEDICAL/PSYCHOLOGICAL**

1. Primary symptom (s) complaint (s) for which treatment is desired.  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

2. Date and conditions surrounding first appearance of each symptom.  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

3. Who diagnosed symptoms? (Name & Address) \_\_\_\_\_  
What was diagnosis? \_\_\_\_\_ When was it diagnosed? \_\_\_\_\_

4. Past/current medical or psychological problems related to primary symptoms: \_\_\_\_\_  
\_\_\_\_\_

5. Last thorough physical examination by a physician. \_\_\_\_\_  
Name of physician \_\_\_\_\_ Date \_\_\_\_\_  
Outcome and recommendations \_\_\_\_\_

6. Dates and outcome of previous medical/neurological workups or interventions (pain/other injections, hospitalizations, surgery, physical or other therapy, brain scan, skull x-ray, clinical EEG or other).

Dates	Kind of Exam or Treatment	Outcome

7. Family physician and other physicians currently treating you (Names, addresses)  
Family Physician \_\_\_\_\_ Address \_\_\_\_\_  
Other Treating Physician \_\_\_\_\_ Address \_\_\_\_\_

Physician to whom you wish a report sent \_\_\_\_\_  
*(Name and Address)*

8. Previous/current psychological/psychiatric experience

Psychologist/Psychiatrist	Dates of Treatment or Exam	Diagnosis

Have you ever been hospitalized for psychological reasons? \_\_\_\_\_ When \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

9. Current medications (Please list all prescribed medications currently used)

Symptom Being Treated	Name of Medication	Dosage	Frequency of Use	Effectiveness (0 – 10)	Side Effects (0 – 10)	Prescribing Physician	Starting Date

10. Relevant medications used in the past and symptoms being treated.

\_\_\_\_\_  
\_\_\_\_\_

11. Use of non-prescription medication (e.g., aspirin, Tylenol, decongestants, sleep medications, nasal sprays, inhalers, vitamins, other supplements).

\_\_\_\_\_  
\_\_\_\_\_

12. Past/current use of stimulants and social drugs (please check and describe frequency).

Alcohol \_\_\_\_\_ Cigarettes \_\_\_\_\_ Marijuana \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_ No Doz \_\_\_\_\_  
Other Substances \_\_\_\_\_

13. Nutritional habits (detailed description of 1 day's typical meals).

Breakfast \_\_\_\_\_  
Mid-Morning Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Mid-Afternoon Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Evening Snack \_\_\_\_\_

Use of stress foods – please circle and describe frequency.

**Sugar    Candy    Desserts    Soft Drinks    Salt    Chocolate**

How often do you eat out? \_\_\_\_\_

14. General health (Prenatal & perinatal events with developmental history). Please use reverse side if more space is needed.

Childhood \_\_\_\_\_  
\_\_\_\_\_  
Adult \_\_\_\_\_  
\_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**15. Medical History: Check Symptoms and Disorders**

Type	Self	Description or Frequency of Occurrence	Other Family Members
Headaches _____			
Arthritis _____			
Allergies _____			
Asthma _____			
Alcoholism _____			
Diabetes _____			
Epilepsy _____			
High Blood Pressure _____			
Heart Disease _____			
G.I./G.U. Disorders _____			
Cancer _____			
Emotional Problems _____			
Insomnia _____			
Other Symptoms _____			
Other Disorders _____			

Describe any occasions when you have lost consciousness or fainted \_\_\_\_\_  
\_\_\_\_\_

16. What are your expectations or reactions concerning your symptoms (e.g., **optimistic, anxious, guilt, frustrated, angry, hopeless, self-doubt, self-pity, fatalistic, withdrawn**, etc.?)

\_\_\_\_\_

Responses of significant others to symptoms (**spouse, family, friends, employer**, etc.) \_\_\_\_\_  
\_\_\_\_\_

**GENERAL/PSYCHOLOGICAL**

17. Please briefly describe characteristics or personality styles of each (5-10 words):

Spouse/boy friend/girl friend \_\_\_\_\_  
\_\_\_\_\_

Self \_\_\_\_\_

Children 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Marital and/or family relationships. What are the major stresses in your family life?

Father \_\_\_\_\_

Mother \_\_\_\_\_

Do you like your job? School? \_\_\_\_\_

What are the major stresses in your job? School? \_\_\_\_\_

How would you describe your relationships with others (friends, employers, employees)? \_\_\_\_\_

Friends \_\_\_\_\_

Employers/Employees \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

What words would you use to describe your typical daily mood?

Morning \_\_\_\_\_

Day \_\_\_\_\_

Evening \_\_\_\_\_

18. How well can you relax when you have no special problems? (**rate from 0-10**) \_\_\_\_\_  
How well can you relax when you need to relax? (**rate from 0-10**) \_\_\_\_\_

19. Do you do anything specifically to relax, i.e., have you any knowledge and/or experience with any of the systematic relaxation techniques, such as meditation, yoga, autogenic training, biofeedback training etc.?

What do you do on a daily basis specifically to relax? When do you do this and how much time do you spend? \_\_\_\_\_

20. Typical daily schedule (please put in approximate times and describe activities during leisure hours).

Time arising \_\_\_\_\_

Spouse home from work \_\_\_\_\_

Dress, etc. \_\_\_\_\_

Dinner \_\_\_\_\_

Breakfast \_\_\_\_\_

Evening activities \_\_\_\_\_

Work schedule \_\_\_\_\_

Lunch \_\_\_\_\_

Go to bed \_\_\_\_\_

Home from work \_\_\_\_\_

Go to sleep \_\_\_\_\_

How many hours per day do you watch television? \_\_\_\_\_

### **TO BE FILLED OUT BY THERAPIST**

#### **MEDICAL/PSYCHOLOGICAL**

1. What emotional feeling is dominant when the symptom is present or most intense? (e.g., **nervousness, worry, fear, anger, frustration**, other) \_\_\_\_\_
2. Do you have any warning that the symptom is coming on or will increase in intensity (e.g., **feeling nervous, depressed, muscle tension, or other mental or emotional state**) \_\_\_\_\_
3. What reduces or alleviates each symptom? (e.g., **activity, medication, food, beverages, relaxation, sleep**, etc.) \_\_\_\_\_
4. What increases the severity of each symptom? (e.g., **foods, stressful situation, activity, medication**) \_\_\_\_\_
5. Have you noticed any time patterns in relation to the occurrence of your symptoms? (e.g., **time of day/ week/month, sleeping vs. waking, menstrual cycle, seasonal change, weather**, etc.) \_\_\_\_\_
6. Have you noticed that certain feelings or situations might be associated with the onset of symptoms? (e.g., stressful events, impending social/familial/occupational engagements, etc.) \_\_\_\_\_



NAME \_\_\_\_\_ DATE \_\_\_\_\_

7. How are daily activities limited before/during/following the appearance of each symptom? \_\_\_\_\_  
\_\_\_\_\_

8. How would your life be different without your symptom (s)? \_\_\_\_\_  
\_\_\_\_\_

9. What, if any, benefits do you receive from your symptoms (e.g., attention from others, opportunity to take it easy, distraction from personal problems) \_\_\_\_\_  
\_\_\_\_\_

10. Detailed description of symptom (s) / complaint (s) for which biofeedback training is desired. For each symptom:

<b>SYMPTOM</b>	<b>LOCATION</b>	<b>QUALITY OF PAIN</b>	<b>INTENSITY (0 - 10)</b>	<b>DURATION</b>	<b>FREQUENCY OF OCCURRENCE</b>

11. Do you experience suicidal thoughts? \_\_\_\_\_  
Have you ever attempted suicide? \_\_\_\_\_  
Do you think you might ever attempt suicide? \_\_\_\_\_