Cynthia Ramirez Psychological Associates, LLC

Intake Form

Please complete the following intake form and bring it to your first session. Please note that information you provide is protected as confidential information.

Name: ____

(Last) (First) (Middle Initial)

Parent/Guardian Name (if under 18):

____

(Last) (First) (Middle Initial)

____

(Last) (First) (Middle Initial)

Date of Birth: _____/_____/_____ **Age:**________ **Gender:** Male____ Female____ Other____

Marital Status:

Never Married_____ Married_____ Domestic Partnership_____
Separated_____ Divorced_____ Widowed_____

Please list any children and their ages:

____

Please list any siblings and their ages:

____

____

Address:____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ______________________ **Okay to leave message?** Yes_____ No_____

Patient Cell Phone:________________________ **Okay to leave message?** Yes_____ No_____

Parent Cell Phone:________________________ **Okay to leave message?** Yes_____ No_____

Parent Cell Phone:________________________ **Okay to leave message?** Yes_____ No_____

Email:____________________________ **Okay to email you**: Yes_____ No_____
Please note: Email correspondence is not considered to be a confidential medium of communication.

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

Name of Therapist:____

Name of Psychiatrist:____

Please list current medications/doses:
____

____

General Health and Mental Health Information

How would you rate your current physical health?
Poor_____ Unsatisfactory_____ Satisfactory_____ Good_____ Very Good_____

Please list any health problems you are currently experiencing:

____

____

How would you rate your current sleep habits?
Poor_____ Unsatisfactory_____ Satisfactory_____ Good_____ Very Good_____

Please list any sleep problems you are currently experiencing:

____

____

How many times per week do you generally exercise?____________

What types of exercise do you participate in?____

Please list any difficulties you experience with your appetite or eating patterns:

____

Are you currently experiencing overwhelming sadness, grief, or depression? Yes_____ No_____

If yes, when did these symptoms begin? ____

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

If yes, when did these symptoms begin? ____

Are you currently experiencing any chronic pain? Yes_____ No_____

If yes, please describe:____

How often do you drink alcohol? ____

How many drinks do you typically have when drinking? _________________________________

How often do you engage in recreational drug use?

Daily_____ Weekly_____ Monthly_____ Rarely_____ Never_____

Drug type: ____

Are you currently in a romantic relationship? Yes_____ No_____

If yes, for how long? ___________________________________

How would you rate your currently relationship, on a scale from 1-10? _____________________

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

____

____

____

Family Mental Health History

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, brother, maternal aunt, etc.).

	Please circle	Family Member
Alcohol/substance dependence	Yes/No	
Anxiety	Yes/No	
Depression	Yes/No	
Domestic Violence	Yes/No	
Eating Disorders	Yes/No	
Obsessive/Compulsive Behavior	Yes/No	
Schizophrenia/psychotic behavior	Yes/No	
Suicide Attempts	Yes/No	
Other:________________________________		

Additional Information

What is your highest level of education/degrees?

____

Are you currently employed? Yes_____ No_____

If yes, what is your current employment situation? ____

Do you enjoy your work? Yes_____ No_____

Is there anything stressful about your current work situation? _______________________________________

____

Do you consider yourself to be spiritual or religious? Yes_____ No_____

If yes, please describe your faith/belief system: ____

What do you consider to be some of your strengths?

____

____

____

What do you consider to be some of your weaknesses?

____

____

____

What would you like to accomplish during your time in therapy?

____

____

____