PSYCHOTHERAPYHELP

PAUL J HANNIG, PHD LMFT

Initial Therapy Client Intake Form

Name _____ Age_____ Birthdate _____

Address _____ Email _____

City _____ State_____ Zip _____

Home Phone _____Work Phone _____Cell Phone:_____

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____ Religion _____

If Client is a Minor, Name of Responsible Adult _____

Name of Closest Friend/Relative_____ Phone _____

Address _____ City _____ State _____Zip _____

There are times when prior medical and psychological records will be requested.
Please make sure that all information given below is correct.

Do You Smoke?_____How Much?_____Do You Drink?_____ How Much? _____

Do You Take Drugs?_____If yes, what kind? _____How often?_____

Last Medical Examination_____Reason _____

Are You Now Under a Doctor's Care?_____If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? Describe:_____

_____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe:

_____

Any Previous Therapy/Counseling? _____If Yes, Name and Phone Numbers of Therapists: _____

_____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

How referred to Dr. Hannig: _____

What do you want to achieve with therapy? _____

_____

_____

_____

_____

Check Any of the Following That May Apply to You:

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ No Appetite
- ☐ Over-Eating
- ☐ Stomach Trouble
- ☐ Bowel Disturbances
- ☐ Always Tired
- ☐ Always Sleepy
- ☐ Unable To Relax
- ☐ Insomnia
- ☐ Recurrent Dreams
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Inferiority Feelings
- ☐ Feel Tense
- ☐ Feel Panicky
- ☐ Fears and Phobias
- ☐ Obsessions
- ☐ Depressed
- ☐ Suicidal Ideas
- ☐ Take Tranquilizers
- ☐ Alcoholism
- ☐ Dangerous Drugs
- ☐ Allergy
- ☐ Asthma
- ☐ Homosexuality
- ☐ Sexual Problems
- ☐ Shy With People
- ☐ Can't Make Friends
- ☐ Afraid Of People
- ☐ Home Conditions Bad
- ☐ Unable To Have A Good Time
- ☐ Always Worried About Something
- ☐ Don't Like Weekends/Vacations
- ☐ Can't Make Decisions
- ☐ Over-Ambitious
- ☐ Financial Problems
- ☐ Gambling
- ☐ Job Problems
- ☐ Can't Keep A Job
- ☐ Other _____

Insurance Company _____ Policy Number _____

Address _____ City _____ State _____ Zip _____

Phone _____ Group Number _____

May we say who we are if we phone your home? _____

May we say who we are if we phone your work? _____

Upon my signature below, I hereby attest that all the information furnished is true and correct.

_____ _____

Signed Date