# *M. Elicia Nademin, Ph.D.*

## PRIVATE & CONFIDENTIAL - CLIENT INTAKE FORM

*Your thorough and accurate completion of this form will provide a comprehensive picture of your background, what brings you in, and how we may best work together to meet your needs and goals. Information provided here will be treated with the same degree of confidentiality as anything you share with me when we meet. Please feel free to skip questions you prefer not to answer. If you run out of room for any item, please use the final section of the form designated for additional notes. In gray shaded areas, please select appropriate responses from the options listed. Please do not write in blue shaded areas designated for office use. Many thanks & WELCOME!*

**Name**_____ **Today's date** _____
***(First, Middle, Last Name)***

**Birth date** _____-_____-_____ **Age**_____ **Gender:** _____

**Ethnicity** _____ **Religion (Optional)** _____

**Primary Language:**_____ **Other Languages:** _____

**Address**_____ **City**_____**State**____**Zip**_____

**Marital Status**: **____Married ____Single ____In Relationship ____Divorced ____Widowed ____Separated**

**Education Completed (Circle): 1-8 9 10 11 12 GED Some College AA BA/BS Master's Doctorate Year?** _____

***Please indicate preferred contact with an (X):*** **( ) Cell (_____)**_____ **( ) Home (_____)**_____
**( ) Work (_____)**_____ ***May I leave messages at all of these?*** ***Y / N***

**Email:** _____***(confidentiality not guaranteed electronically)***

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***Billing/Responsible Party (if Different from Above)*: Name :** _____

**Address**_____**City**_____**State**___ **Zip**_____

**Preferred Method of Payment: ( ) Cash ( ) Check** ***(Please note, I do not accept credit card at this time.)***

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**Contact person in case of emergency:** _____**Relationship**_____
**Telephone (_____)** _____ **Other Telephone (_____)** _____
**Do I have permission to contact this person in the event of an emergency?* **Y / N** *Please initial here*: _____

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**Briefly, please explain what brings you in today?**_____

**When did this issue first present, and why get help NOW??**_____

**How strongly do you want treatment? Very strongly! Somewhat I could do without it, if necessary I really don't want help**

**Sleep (past month):** ☐ No problems ☐ Too Much Sleep ☐ Not Enough Sleep / # Hours per night: ___ # Hours per day: ___

☐ **Trouble falling asleep due to:** ☐ pain ☐ thoughts ☐ excessive energy ☐ environment (e.g., noise/light) ☐ Don't Know

☐ **Trouble staying asleep due to:** ☐ pain ☐ urinary frequency ☐ restlessness ☐ environment (e.g., noise/light) ☐ Don't Know

☐ **Early awakening due to:** ☐ pain ☐ urinary frequency ☐ restlessness ☐ environment (e.g., noise/light) ☐ Don't Know

**Do you experience nightmares? Y / N If yes, how often?** _____

**Have you ever gone days with little or no sleep yet felt energized and active still? Y / N**

**Do you engage in impulsive, high-risk behaviors? Y / N If yes, please list:** _____

**CONFIDENTIAL CLIENT HISTORY** **CLIENT:**

***Please check box if you have experienced symptoms below over past two weeks:***

| | | |
|---|---|---|
| O Frequent sadness/tearfulness | O Loss of interest in previously enjoyed activities | O Guilt/Regrets |
| O Fatigue/loss of energy | O Difficulties concentrating/decision-making | O Anxiety/worry |
| O Change in weight/appetite | O Feelings of Loneliness/Emptiness | O Sexual Dysfunction |
| O Thoughts of death/dying | O Feelings of worthlessness | O Irritability |
| O Feelings of hopelessness | O Work/school/family problems | O Relationship problems |
| O Social Withdrawal | O Hearing/seeing things that aren't there | O Mood swings |

## EDUCATION & OCCUPATIONAL HISTORY

What grades did/do you receive in school? _____

Ever been in special education or gifted classes? **Y / N** If yes, for which subject(s)?: _____

Current job title? _____ How many hours/wk do you work? _____

How long have you been at this agency? _____ How satisfied are you at work? **__ Very __ Somewhat __ Not**

If unemployed, list reason: _____ At what age did you begin working? _____

Please list last 3 jobs held (from most to least recent), length of time at each, & reason for leaving: _____

_____

_____

What are you future occupational plans? _____

(OFFICE USE ONLY): _____

_____

## FAMILY DATA

Where were you born? _____ And raised? _____

Did your biological parents raise you? **Y / N** If No, who did and during what years? _____

Is your father still living? **Y / N** If yes, how is/was your relationship with him? Excellent Good Fair Poor

His occupation: _____ How often do you talk/meet? _____

Describe his personality & attitude toward you: _____

*If deceased, state cause & year/age at time of death*: _____

Is your mother still living? **Y / N** If yes, how is/was your relationship with her? Excellent Good Fair Poor

Occupation: _____ How often do you talk/meet? _____

Describe her personality & attitude toward you: _____

*If deceased, state cause & year/age at time of death*: _____

Are your biological parents still married? **Y / N** If not, how old were you when they divorced? _____

If you have a step-parent, how old were you when your natural parent(s) remarried? _____

How is your relationship with your step-parent(s)*:* **Great Good & Bad Not bad Poor**

If you have siblings, list names, ages, gender, jobs, & your relationship with each: _____

_____

_____

_____

How would you describe your childhood home? Please comment on compatibility between parents and between parents and children: _____

_____

_____

Were you able to confide in your parents? **Y / N** Siblings? **Y / N** If no, why? _____

What forms of discipline were used in your home? _____

(OFFICE USE ONLY): _____

_____

_____

## Relationship History

How satisfied are you with your current relationship status (e.g., single, married, divorced)? **__ Very __ Somewhat __Not**

Are you currently in a committed romantic relationship? **Y / N** **If yes, h**ow long have you known your partner? _____

Spouse/Partner's personality: _____

In what areas are you compatible? _____

In what areas are you incompatible? _____

Describe areas of conflict with your partner: _____

_____

**If married**, how long were you engaged? _____ When were you married? _____

Current Spouse's/Partner's Name: _____ Age: ___ Occupation: _____

How is your relationship with your in-laws: **Great Good & Bad Not bad Not well**

Were you married before? **Y / N** If yes, please list year(s) of prior marriage, divorce, & reason(s) for divorce: _____

_____

_____

_____

Do you have children? **Y / N** If yes, please list names, ages, sex, and brief description of each child's personality. Indicate if either is from a previous marriage._____

_____

_____

Describe any areas of conflict with your children: _____

(Office Use Only): _____

_____

_____

## Social History

Do You Live in a House, Hotel, Apartment, Condo, Other? _____ Do you Rent or Own?

With Whom Do You Live?_____

Do you make friends easily? **Y / N** If no, why do you think this is? _____

Do you tend to keep friends? **Y / N** How often do you spend time with friends?_____

What kinds of things do you do with friends? _____

How is most of your free time occupied? _____

Did you experience disciplinary problems in school? **Y / N** If yes, please explain: _____

_____

## Sexual History

Are you current sexually active? **Y / N** **If yes,** how many days/month do you engage in sex? _____

If you care to share additional information about your intimate relationships, please do so here: _____

_____

_____

(Office Use Only): _____

_____

_____

_____

_____

_____

## Medical History

**Please provide the following information about your general health history.**
Please Circle P for personal health history. Circle F for areas of family history.

P F Alcoholism/Illicit Drug use
P F Allergies (list): _____
P F Asthma, Bronchitis
P F Anxiety
P F Back, neck, spine, disc problem/injury
P F Cancer of any type
P F Deformity
P F Diabetes
P F Ear/Nose/Throat disease or infection
P F Eating disorder: anorexia, bulimia
P F Epilepsy/seizure disorder, convulsions
P F Fainting
P F Heart problem or condition`
P F Hepatitis/liver disorder
P F HIV/Aids
P F Hormonal/Thyroid/Pituitary
P F Hypertension; blood pressure disorder
P F Hysterectomy
P F Immune system disorder, Lupus
P F Mental illness (e.g., depression)
P F Migraines/Headaches
P F Prosthetic implant/artificial limb
P F Male organ irregularity: prostate, impotence
P F Sexually transmitted diseases
P F Skin disorders/lesions/tumors/cysts
P F Stomach/ colon/ Crohn's disease disorder
P F Stroke
P F Suicide
P F Ulcers, digestive disorders
P F Weight problems

P F Other significant medical conditions, explain : _____

Did you experience any birth complications or developmental delays (such as with crawling/walking/talking)? **Y/N**
**If yes**, please list: _____

How was your health during childhood/adolescence: **Excellent Good Fair Poor**

How is your current physical health: **Excellent Good Fair Poor** ***If female***, are you/could you be pregnant? **Y / N**

How is your vision? **Good Good With Correction (Glasses/Contacts) Poor** **Height:** _____ **Weight:** _____

Do you or have you had:
Speech difficulties? **Y/N** If yes, describe: _____
Hearing difficulties? **Y/N** If yes, describe: _____
Motor difficulties? **Y/N** If yes, describe: _____
Any allergies? **Y/N** If yes, describe: _____

Have you ever had surgery? **Y /N** If yes, please list type of surgery, when, where, why, & any complications: _____

Please check if you have experienced any of the following conditions and indicate date(s): _____
[ ] Head Injury [ ] Loss of consciousness/concussion [ ] Seizures [ ] convulsions [ ] other neurological diagnosis

## Mental Health History

Have you been in therapy before? (Please list all persons seen, dates, for what, for how long each time, & whether it helped):

Have you ever been hospitalized for mental illness? **Y / N** If yes, for what, when, where, and for how long? _____

Please list past events that have profoundly affected you (e.g., serious car accidents; violence): _____

**If any**, do you feel you relive any of these, think of them when you don't want to, or avoid reminders of them? (such as flashbacks/nightmares)? **Y / N** **If Yes,** please explain: _____

Is there a history of family mental illness (e.g., depression, suicide, substance abuse, schizophrenia)? **Y / N / DK**
**If yes**, please list issue(s) & whether treatment was received: _____

Do you or have you taken medications for emotional/behavioral issues (e.g., anxiety, depression, sleep)? Y /N
**If yes**, Please list medication, indicate time of use and whether you benefitted: _____

(Office Use Only): _____

**Family Physician / Name:** _____ **Phone** (_____) _____
**Psychiatrist, if applicable / Name:** _____ **Phone** (_____) _____

***Release of Information:*** "I give Dr. Nademin permission to contact these doctors regarding health issues relevant to my ongoing treatment, as necessary. I understand that this information will remain confidential."

_____ **(Signature, Date)**

## Substance Use & Legal History

Do you smoke cigarettes? ___ **Yes** ___ **No** If no, h**ave you ever smoked cigarettes & stopped?** ___ **Yes** ___ **No**

**If Yes to either,**

a) **How many cigarettes per day?** _____

b) For h**ow many years?** _____

c) **If you quit, when?** _____ How did you quit? _____

*Please Indicate amount and Frequency of any Substance you use or have used below:*

| | Current | Past | | Current | Past |
|---|---|---|---|---|---|
| Alcohol | | | Narcotics / Pain | | |
| Tobacco | | | Diet Pills | | |
| Caffeine (tea, coffee, Soda) | | | Sleeping pills | | |
| Cocaine | | | Anti-Anxiety Meds | | |
| Marijuana | | | Anti-Depressants | | |
| Heroine | | | Other Illegal Drug | | |

Have you ever had a problem with (or received treatment for) alcohol or other drug use? Y /N

If yes, please explain: _____

_____

_____

Have you ever served in the military? **Y / N** Have you ever been arrested? **Y /N** If yes, were you convicted? **Y /N**

If convicted, what was the charge? _____Have you ever served jail time? **Y / N**

Are you currently or have you ever been involved in a lawsuit? **Y /N** If yes, please explain: _____

_____

(Office Use Only): _____

_____

_____

## Timing

Why did you choose to come for treatment NOW? _____

_____

**How stressful has your life been during the past 6 months? *(Circle one)***

**I've had NO stress** **Much less stressful than usual** **Less stressful than usual**
**Average level of stress** **More stressful than usual** **Much more stressful than usual**

***Please circle Yes or No to indicate (current) greater than usual stress in the following areas:***

- Work: **Yes** **No**
- Health: **Yes** **No**
- Relationship with spouse/significant other: **Yes** **No**
- Activities related to your children: **Yes** **No**
- Activities related to your parents: **Yes** **No**
- Legal/financial trouble: **Yes** **No**
- School: **Yes** **No**
- Moving: **Yes** **No**
- Other: _____

Briefly explain any items above to which you responded "Yes," unless covered elsewhere: _____

_____

_____

Are you planning major life changes (i.e., new job, moving, relationship, etc.) in the next 6 months? **Y / N**

If yes, please specify: _____

(Office Use Only): _____

_____

_____

## Self-Portrait

Please provide a word or two that the following persons would describe you as:

a) Your spouse, lover, fiancée, partner_____

b) Your best friend_____

c) Your worst enemy (or someone who dislikes you)_____

d) Yourself_____

## Resilience factors

When did you last feel both physically and emotionally healthy for a sustained period of time? _____

_____

Who are the most significant people in your life? _____

_____

Who is your biggest supporter? _____

What were your hobbies/interests as a child? _____

What are your current hobbies/interests?_____

Please list **5** goals you have for the future? _____

_____

_____

_____

_____

What is your primary hope/goal for our work together? _____

_____

_____

***Please provide any additional details you wish to share here:*** _____

_____

_____

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(Office Use Only): _____

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# MEDICATION LIST

PATIENT NAME_____ M F DOB_____ WT_____

PHARMACY: NAME_____ PHONE_____

ALLERGIES_____

_____

***PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE OR HAVE TAKEN IN THE PAST 3 MONTHS***

| MEDICATION | REASON FOR USE | START DATE | DOSAGE | FREQUENCY | SIDE-EFFECTS |
|---|---|---|---|---|---|
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COMPLIANCE NOTES _____

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