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Licensed Clinical Psychologist

ADULT INTAKE FORM

Date: _____

Full Name: _____ Preferred Name: _____

Sex assigned at birth: ☐ M ☐ F Gender Identity/Pronoun (optional): _____

Age: _____ Birthdate: _____ Birthplace: _____

Marital Status: _____ Ethnicity: _____

Primary Language: _____ Other Languages: _____

Grade (if applicable): _____ Highest Degree: _____

Person completing form: _____

Current Employer: _____ Occupation: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone #: _____ Okay to leave message? ☐ Y ☐ N

Work Phone: _____ Okay to leave message? ☐ Y ☐ N

Emergency Contact Name and Number: _____

Who may I thank for your referral to my office? _____

Cancellation Policy: Appointments must be cancelled or rescheduled at least 72 business hours in advance for testing appointments, and 48 hours in advance for therapy appointments. Failure to provide this notice will result in a late cancellation fee (e.g., $275 per hour), and any future appointments may require prepayment in full.

_____ _____

Signature Date

In your own words, please describe the reason that you are seeking out therapeutic services or an evaluation.

How long have you been feeling this way or concerned and what made you decide to come in at this time?

Please mark any areas of difficulty that apply to you:

☐ Sleep	☐ Eating/appetite concerns	☐ Depressed/Irritable Mood
☐ Anxiety	☐ Feeling Overwhelmed	☐ Stress
☐ Significant fear	☐ Low energy	☐ Excessive energy
☐ Panic/anxiety Attacks	☐ Postpartum Depression/Anxiety	☐ OCD symptoms
☐ Social concerns	☐ Withdrawal	☐ Parenting concerns
☐ Overeating or Binge eating	☐ Food restriction	☐ Laxative Use
☐ Suicidal Ideation	☐ Suicidal Intent/Plan	☐ Hopelessness
☐ Concentration	☐ Memory	☐ Other

Primary Care Physician including phone #: _____

Medication (and dosage) taken at this time: _____

Date of last medical checkup? _____

What is your present health? ☐ Excellent ☐ Good ☐ Fair

Please explain: _____

Please list any previous diagnoses, including date of diagnosis:

Have you ever been hospitalized for psychiatric reasons? If yes, please state incident and dates.

Do you drink alcohol more than once per week? If so, how often and how much?

Do you smoke? _____

Do you use any recreational drugs? If so, how often and what type?

Do any family members have a history of mental health concerns? ☐ No ☐ Yes If yes, who and what kind?

FAMILY INFORMATION

If applicable, please complete the following:

Partner's Name: _____ Partner's Age: _____

Partner's Occupation: _____

If you have children, please list their names and ages:

Name	Sex	Age

Who currently lives in your residence (Adults and children):

Name	Relation	Sex	Age

Family of Origin: Please list parents and siblings:

Name	Relation	Sex	Age	Location

Please share any other information that you feel would be helpful for Dr. Cherwony to know about you at this time.