ALISON FREEMAN, Ph.D

Clinical Psychologist
www.dralisonfreeman.net
email: draf@drafreeman.com

INTAKE FORM

In order for me to best help you, please fill out the following information. All information is strictly confidential and cannot be legally released without your written permission. I appreciate your taking the time to provide with as much information as possible.

NAME _____ TODAY'S DATE _____
Last First Middle
ADDRESS_____
Street City State Zip
OCCUPATION _____HOME PHONE_____

EMPLOYED AT_____ WORK PHONE_____

EMAIL Address _____ CELL PHONE _____

Birth date _____ Birthplace _____

Marital Status: Single _____Married _____ Separated _____Divorced _____

Highest grade completed _____

REFERRED BY: Self _____ Doctor _____ Insurance Co. ____ Other _____

PRIMARY INSURANCE COMPANY _____

YOUR ID/GROUP# _____ INS. CO. PHONE NUMBER _____

PRIMARY INSURANCE COMPANY ADDRESS _____

INSURED'S NAME_____ INSURED'S BIRTHDATE _____

INSURED'S ID/POLICY# _____Phone # _____

SECONDARY INSURANCE _____ ID/ NUMBER_____

SECONDARY INS. CO. PHONE NUMBER _____

MAJOR REASON FOR SEEKING HELP AT THIS TIME?_____

_____

_____

_____

WHEN DID THIS SITUATION START? _____

What are you feeling/emotions? (Circle all that apply)

Sad	Hurt	Scared	Alone	Frustrated	Anger
Happy	Fear	Disgust	Surprise	Confused	Jealous
Critical	Hateful	Anxious	Sensitive	Apathetic	Disengaged
Awful	Open	Empty	Rejected	Worried	Terrified
Worthless	Insecure	Inferior	Distant	Inadequate	Insignificant
Furious	Proud	Mad	Hopeful	Indifferent	Powerful
Ignored	Isolated	Excited	Hesitant	Powerless	Abandoned
Joyful	Distant	Shocked	Insecure	Skeptical	Overwhelmed
Hostile	Violated	Furious	Lonely	Alienated	Threatened
Bored	Accepted	Guilty	Eager	Perplexed	Vulnerable

PLEASE LIST PREVIOUS THERAPY, COUNSELING OR HOSPITALIZATIONS

Year	Therapist	Location	How long?	Results?

_____

_____

_____

HOW LONG HAVE THESE THINGS BEEN BOTHERING YOU?

_____

_____

WHAT HAVE YOU TRIED TO DO SO FAR_____
_____

_____

How much time do you spend on the computer with non-work/school related activities
ie Facebook, Twitter, social media, gaming, etc? _____

MEDICAL HISTORY

Date of last medical examination : _____

Any medications and for
what?_____

_____

List serious illnesses, injuries, surgeries or hospitalizations and dates:
_____
_____

_____

FAMILY INFORMATION

NAME RELATIONSHIP AGE? OCCUP? WHERE LIVE? HOW YOU GET ALONG?

_____

_____

_____

_____

_____

Put an * next to the name of anyone who has a history of mental illness, alcoholism, drug use or eating disorder.

Put two ** next to their name if it is current.

Put *** if deceased

WHO DO YOU LIVE WITH NOW? RELATIONSHIP? HOW LONG?

_____

_____

What do you do for exercise or working out?

_____

_____

How often do you work out? _____

PAST OR CURRENT USE OF DRUGS AND ALCOHOL (HOW OFTEN?)

	Past	Current
Alcohol	_____	
Marijuana	_____	
Cocaine	_____	
Cigarettes	_____	
Coffee	_____	
Sleeping Pills	_____	
Other	_____	

PLEASE CHECK ANY/ALL OF THE FOLLOWING CONCERNS

	Mild	Moderate	Serious
____ Headaches	_____	_____	_____
____ Loneliness	_____	_____	_____
____ Worried	_____	_____	_____
____ Depressed	_____	_____	_____
____ Trouble concentrating	_____	_____	_____
____ Trouble sleeping	_____	_____	_____
____ Nightmares	_____	_____	_____
____ Stomach pains	_____	_____	_____
____ Feeling hopeless	_____	_____	_____
____ Panic Attacks	_____	_____	_____
____ Weight change	_____	_____	_____
____ Eating Issues	_____	_____	_____
____ Financial Hardship	_____	_____	_____
____ Trouble with boss	_____	_____	_____
____ Trouble with relationship(s)	_____	_____	_____
____ Ready to Explode	_____	_____	_____
____ Drink too much	_____	_____	_____
____ Feelings of unreality	_____	_____	_____
____ Obsessive Thoughts	_____	_____	_____
____ Dizziness/numbness	_____	_____	_____
____ Loss of Sexual Desire	_____	_____	_____
____ Suicidal Feelings	_____	_____	_____

PAST HISTORY:

What is the story surrounding your birth? Where are you in the birth order in your family? Do you think you were a planned pregnancy? What was going on in the family when you were born?

_____

_____

Years 0-3
Family events? Who was your caregiver? Which parent were you closest to and why? Any moves, births, illnesses? Deaths? Any physical, sexual or emotional trauma?

_____

_____

Years 3-10
What was family life like in your early childhood? Elementary School? Extracurricular events? How was making friends? Who did you feel safest with and why? Any physical, sexual or emotional trauma? _____

_____

_____

Years 10-16
What were social relationships like for you? Did you have a best friend? How was that relationship? Who did you confide in? How was puberty? How did you do in school? Any physical, sexual or emotional trauma? _____

_____

_____

Years 16-21
How was high school for you? Significant relationships? Any Sexual relationships? Transitioning to adulthood – how did that go? Who were in your social group? Do you think that

you matured early, late, right on time? Did you go to College? Did you have after high school plans? Did they happen or not? _ _____

_____

_____

Years 21 – Now
What have you done for work? Are you satisfied with your work life? What have intimate relationships been like for you? How many longer term relationships? What is your social life like? What do you like to do for fun? Do you know what makes you happy?_____

_____

_____

Anything else you would like for me to know? _____

_____

_____

EMERGENCY CONTACT #1 Name/Nbr# _____

Were you referred by someone? yes ____ no _____ If yes, please give me their name:

_____

I like to thank people for their trust and referrals. If I may do so, I would like to ask your permission to give either written or verbal acknowledgement to the person who referred you to me.

Thank you for taking the time to answer this form and I look forward to working with you.