Orange County Health Psychologists, Inc.

## Intake Information

**Name:** ______________________ Date of Birth: ______________ Age: ________

Home Address: ______________________________________________

City: ______________________________ State: ________ Zip: __________

Home/evening phone: ______________________ Cell: ______________________

Work Phone: ______________________ E-mail: ______________________

Employer: ______________________ Job Title: ______________________

Driver's License Number: ________________ Social Security Number: ________________

**Chief Concern**

*Please describe the main difficulty that has brought you in today:* ______________________

______________________________________________

______________________________________________

**Prior Treatment**

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
❑ No ❑ Yes If yes, please indicate:

When?____________From whom?______________For what?______________

With what results? ______________________________________________

2. Have you ever taken medications for psychiatric or emotional problems?

❑ No ❑ Yes If yes, please indicate:

When?____________From whom?____________Which medications?______________

With what results? ______________________________________________

**Medical care:** From whom or where do you get your medical care?
Clinic/doctor's name: ______________________________ Phone: ______________

Address: ______________________________________________

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No ❑ Prefer to discuss first

**Emergency Information**
If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: ______________________ Phone: ______________ Relationship: ______________

**Referred By** ______________________ **Phone calls, mail and email will be discreet, but are there any restrictions for contacting you?** ______________________________

**Signature** ______________________________ **Date** ______________