

# Deborah C. Neel, Ph.D.

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## Intake Information

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

It is important to get to know you and the factors influencing your decision to seek therapy. Please complete this form completely and honestly. It is essential to have very detailed information and I understand that it may feel intrusive.

### I. Health History (birth to present):

*(additional information can be added on the back of this page)*

General Description	Illnesses & Treatments	Surgical Procedures
Childhood:		
Adolescence:		
Adulthood:		

### II. Current Health:

*(additional information can be added on the back of this page)*

General Description	Illnesses & Treatments	Surgical Procedures

**Specific difficulties:** (check any that apply)

headaches       loss of appetite       sedatives usage       dizziness       bowel disturbances  
 fainting spells       fatigue       palpitations       insomnia       stomach trouble  
 nightmares       alcoholism       allergies, describe: \_\_\_\_\_  
 other, describe: \_\_\_\_\_

*(additional information can be added on the back of this page)*

Substance Intake	No	Yes	frequency	amount	type
Tobacco					
Alcohol					
Non-prescription drugs					
Supplements					
Other					

Special diet? If so, describe: \_\_\_\_\_

**III. Current medications**

*(additional information can be added on the back of this page)*

Medication	Dosage/ Date began	Condition Prescribed for	Prescribed by	Side Effect Y/N (describe)

**Primary Care Physician:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Psychiatrist: (if applicable)**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Other Health Care Providers (e.g. Therapists, Life Coach, etc.): (if applicable)**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_

**IV. Mental Health**

Briefly describe how you *currently* feel emotionally?

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Have you sought mental health services in the past? Type of Treatment: Inpatient Outpatient NA  
Date(s): \_\_\_\_\_ Describe symptoms/treatment:

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**Why are you currently seeking treatment? (presenting problem):**

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**Symptoms:** (check any that apply)

- |   |   |  |             |
|---|---|--|-------------|
| <input type="checkbox"/> depressed mood         | <input type="checkbox"/> hopelessness           | <input type="checkbox"/> paranoia                      | Other _____ |
| <input type="checkbox"/> concentration problems | <input type="checkbox"/> inappropriate anger    | <input type="checkbox"/> self-injurious behavior       |             |
| <input type="checkbox"/> anxiousness            | <input type="checkbox"/> impulsivity            | <input type="checkbox"/> sexual function (neg. change) |             |
| <input type="checkbox"/> decreased energy       | <input type="checkbox"/> irritability           | <input type="checkbox"/> sleep disturbance             |             |
| <input type="checkbox"/> grief                  | <input type="checkbox"/> guilt                  | <input type="checkbox"/> gender issues                 |             |
| <input type="checkbox"/> hyperactivity          | <input type="checkbox"/> tearfulness            | <input type="checkbox"/> weight change                 |             |
| <input type="checkbox"/> memory problems        | <input type="checkbox"/> obsessions/compulsions | <input type="checkbox"/> worthlessness                 |             |
| <input type="checkbox"/> panic attacks          | <input type="checkbox"/> elevated mood          | <input type="checkbox"/> relationship problems         |             |
| <input type="checkbox"/> feelings of suicide    | <input type="checkbox"/> eating disturbance     | <input type="checkbox"/> concern of substance use      |             |
- Less than 1 month       1-6 months       7-11 months       more than a year

**V. Medical Tests- your own**

*(and list family members with abnormal results)*

Test	Date	Results
Thyroid (T3/T4/TSH)		
Hormonal levels (free testosterone/ total testosterone)		
Diabetes		
Cardiovascular Disease		
Sexually Transmitted Disease		
Other		

List any other medical problems that doctors have diagnosed (and dates).

Other illnesses or conditions within family? Parents? Grandparents? Siblings?

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**VI. Significant Others/ Live with/ etc.**

Spouse/Partner: \_\_\_\_\_

How long together? \_\_\_\_\_

Married? (Date of wedding) \_\_\_\_\_

Children (names)/Ages

_____	_____	_____	_____
_____	_____	_____	_____

**VII. Occupation/brief summary of your job description (any stressors?)**

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**VIII. Family of Origin**

Parents? Grandparents? List Siblings? Step parents? Etc.

	Alive? or Age/Cause of Death	Where currently living? Married?	Medical Conditions	Mental Health Treatment? Date/Diagnosis
Mother				
Father				

**IX. Your GOALS for treatment**

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**X. Additional information that you would like to share**

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