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Intake History

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:		

Were you a bed wetter? _____ If so, until what age? _____

How was it handled?

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:

(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:

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: _____

III. Mental Health

Describe how you feel emotionally?

Have you ever had mental health difficulties? Previous treatment? _____ Date(s) _____

Provider name _____ telephone: _____ fax: _____

Address: _____

Would you like me to contact previous provider? YES NO

Why are you currently seeking treatment? (presenting problem) _____

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 | _____ |
| <input type="checkbox"/> Less than 1 month | <input type="checkbox"/> 1-6 months | <input type="checkbox"/> 7-11 months | <input type="checkbox"/> more than a year |

IV. Medical Tests (or 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 medical problems that other doctors have diagnosed

V. Significant Others/ Live with/ etc.

Spouse/Partner _____

How long together? _____

Children/Ages

VI. Family of Origin

Parents? Grandparents? Siblings? Etc.

	Alive? Or Age of Death and Cause of Death	Where currently Living? Married	Medical Conditions	Mental Health Treatment? Date/Diagnosis
Mother				
Father				

VII. Your goals for treatment

VIII. Additional information that you would like to share