Alexandra Laifer, Ph.D.
Clinical Psychologist

Helping You Achieve Personal Growth & Well-Being

INTAKE FORM

Please complete the following confidential information to help us in providing services to you:

Name: _____

Street Address: _____

City: _____ **Zip Code:** _____

Telephone: (home)_____ **(cell)** _____

Email address: _____ **SSN:** _____

Age: _____ **Date of Birth:** _____ **Race/Ethnicity:** _____

Marital Status: _____

Please list any children and their age: _____

Occupation: _____ **Employer:** _____

***If using TriCare*:**

Sponsor Name: _____ **ID#:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Telephone: (day) _____ **(eve)**_____

Address: _____

***Please describe your reasons for seeking therapy at this time*:**

_____

_____

_____

_____

_____

_____

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www.dralexandralaifer.com

How long have you been having these difficulties?

_____

_____

Please describe any major life changes that have occurred recently:

_____

_____

_____

_____

If you have ever received services from a mental health provider (i.e., psychologist, psychiatrist, other counselor), please describe it below:

When With Whom For What Problem Was it helpful?

_____

_____

_____

_____

_____

Please list any medications you are taking (prescription or over-the-counter):

Medication Dosage Date Started Purpose

_____

_____

_____

_____

_____

Name, Address, and Phone of Personal physician (family, internist):

_____

Name, Address, and Phone of Psychiatrist (if applicable):

_____

How would you rate your current physical health? (circle one):

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (circle one):

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

_____

Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

Please describe your alcohol, tobacco, and/or other drug use:

Substance Used **Frequency**

_____

_____

_____

Family Mental Health History

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (father, mother, maternal grandmother, uncle, etc.).

	Please Circle			Family Member
Alcohol/Substance Abuse	Y	/	N	
Anxiety	Y	/	N	
Depression	Y	/	N	
Domestic Violence	Y	/	N	
Eating Disorders	Y	/	N	
Obesity	Y	/	N	
Obsessive Compulsive Behavior	Y	/	N	
Schizophrenia	Y	/	N	
Suicide Attempts	Y	/	N	

Would you consider yourself to be spiritual or religious? **Y / N**

If yes, please describe your faith or belief:

_____

_____

Please describe any positive health behaviors (i.e., exercise, meditation, other activities):

_____

_____

_____

_____

Any other information that might be helpful for us to know:

_____

_____

_____

_____

Who referred you to us?

_____

_____

_____ _____

Signature **Date**