INTAKE SHEET

Name _____ DOB _____

Address: Street _____City _____ Zip _____

Phone: Home ( ) _____ Cell ( ) _____

E-mail: _____

Do you live alone? ____ If not, who lives with you ? _____

Your family:

Father: Living (l) or deceased (d)? _____ If deceased, your age at the time of his death?_____

Cause of his death and when?_____ If alive, father's present age?_____

Name _____Occupation:_____

Medical/psychological Problems:_____

Mother: Living (l) or deceased (d)? _____ If deceased, your age at the time of her death?_____

Cause of his death _____ If alive, mother's present age?_____

Name _____ Occupation: _____

Medical/psychological problems: _____

Siblings:

Number of siblings: ___ Names and ages_____

_____

Family/School/Social History

Last grade completed: _____ Occupation _____

Single/Marital/Partner Status _____ Since _____ Ethnicity _____

Spouse/partner: Living or deceased? ___ If deceased, your age at the time of her/his death? _____

Cause of her/his death? _____ If living, present age _____

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phone (310) 569-0106 **email** PsychotherapyArt@aol.com

Partner's name _____ Occupation:_____

Partner's medical/psychological Problems:_____

_____

Religion: a) in childhood _____ b) as an adult_____

Do you have any children, if yes please list their name, age, and sex below:

Name _____ DOB _____ Age ____ Sex _____

Name _____ DOB _____ Age ____ Sex _____

Name _____ DOB _____ Age ____ Sex _____

Name _____ DOB _____ Age ____ Sex _____

Name _____ DOB _____ Age ____ Sex _____

Medical and Mental Health

Please list any medical/psychological conditions/diagnoses and year(s): _____

_____

Please list any medication(s), including dosage and what they are for:

Medication _____ Dosage _____ Reason _____

Medication _____ Dosage _____ Reason _____

Medication _____ Dosage _____ Reason _____

Medication _____ Dosage _____ Reason _____

Medication _____ Dosage _____ Reason _____

Who are the prescribing doctors?

Name_____Med. Specialty_____ phone_____

Name_____Med. Specialty_____ phone_____

Name_____Med. Specialty_____ phone_____

Goals for psychotherapy/counseling: _____

_____

_____

Please describe what caused you to seek therapy at this time? Did something happen?

_____

_____

Are you currently receiving psychotherapy from somewhere else than Andrea von Troschke? _____

If yes, whom are you seeing? _____

Have you ever received psychotherapy before? ____ If yes, with whom? _____

Was it helpful? If yes, how?

_____

What was unhelpful? _____

Are you presently in group therapy? _____ Name of group/location _____

Emergency Information

Please tell me whom I may contact in case of an emergency:

Name _____ Relationship _____ Phone ( ) _____

Address _____ City/State _____ Zip _____

Insurance information

Primary insurance holder's name: _____

DOB_____ Relationship to insurance holder _____

Insurance Name/Program _____ phone # _____

Insurance ID_____ SSN# _____ Group Policy Nr._____

Employer _____

Referral

Who referred you? Name _____ or which website _____