Scott Lingen, Psy.D.

CONFIDENTIAL Client Intake Form

Client Name:_____ **E-mail**: _____

Address:_____**City**_____**Zip**_____

Cell Phone #:_____ **Home Phone #**_____

Date of Birth: _____/_____/_____ **How were you referred to my practice**? _____

Contact in case of emergency:_____ **Phone**: _____

Have you had previous psychological care? Yes ☐ No ☐ If so, When?_____

Have you ever been hospitalized for a psychological difficulty? Yes ☐ No ☐ If so when? _____

Please list any medications you are currently taking, w / dosage, both prescription & over the counter:

_____

_____

Are you currently under the care of a psychiatrist or other mental health Professional? Yes ☐ No ☐

Do you currently have any major medical conditions of which I should be aware: Yes ☐ No ☐

If so, please describe:_____

Please indicate any current usage and amount of the following substances:

☐ Alcohol; Drinks/week _____ **☐ Cigarettes/day** _____ **☐ Marijuana** _____

Do you currently use any illicit substances, even occasionally? Yes ☐ No ☐ _____

Other than noted above, please indicate any past usage of alcohol, tobacco, or illicit substances:

_____

Please indicate any stressors you are experiencing now or have experienced within the past 6 months:

	Partner relational issues		**Difficulties at work**		**Financial difficulties**
	Recent separation/divorce		**Academic difficulties**		**Sexual difficulties**
	Conflicts with family		**Work / family conflict**		**Physical abuse**
	Conflicts with friends		**Job termination**		**Domestic violence**
	Illness of a family member		**New job**		**Personal injury**
	Death of a family member		**Change in residence**		**Emotional abuse**
	Death of a spouse		**Legal problems**		**Sexual Orientation/Identity**
	Death of a close friend		**Retirement**		**Other:**

Continued Next Page

Please place a check to indicate if any of the difficulties listed below apply to you currently (C) or have occurred for you at any time in your past (P):

C	P	Difficulty	C	P	Difficulty
		Depression / sadness			Anxiety / nervousness
		Suicidal thoughts			Nightmares
		Recurrent / intrusive thoughts			Chills or hot flashes
		Difficulty sleeping			Explosive anger
		Oversleeping			Homicidal thoughts
		Overeating			Excessive fears or phobias
		Loss of appetite			Chest pain or discomfort
		Loss of interest in pleasurable activity			Palpitations, pounding heart
		Weight gain			Trembling or shaking
		Significant unexplained weight loss			Nausea or abdominal distress
		Feelings of worthlessness			Feeling dizzy, lighthearted, or faint
		Feelings of guilt			Fear of losing control or going crazy
		Fatigue or loss of energy			Fear of dying
		Diminished ability to concentrate			Numbness or tingling sensations
		Feeling completely helpless			Feeling hypersensitive / hyper-aroused
		Feeling completely hopeless			Having flashbacks of a traumatic event
		Feeling dissociated from reality			Engaging in impulsive behavior

Is there anything else that you think I should know about you that you believe will be important to the work we will be doing together?

_____

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Thank you