

# **NEW PATIENT INTAKE FORM**

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Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer all items carefully. If you do not understand an item, I am happy to provide you with clarification. After carefully reading the Service Agreement and Privacy Notification form please sign and date it. Please bring this completed intake form to your first appointment with me. Thank you.

## **PSYCHOTHERAPY HISTORY**

Please describe your reason/concern for seeking therapy today:

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Are you currently having any suicidal or homicidal thoughts? \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain:

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Have you received prior mental health services? \_\_\_\_ Yes \_\_\_\_ No

Clinician's name, address and dates of previous mental health services:

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May I contact your previous clinician? (with the appropriate release) \_\_\_\_ Yes \_\_\_\_ No

**AREAS OF CONCERN**

Please circle any of the following problems or concerns, which pertain to you (couples may use initials).

If you circle more than three highlight your most urgent concerns:

Nervousness	Depression/Sadness	Sexual Problems
Separation/Divorce	Finance Issues	Sleep Problems
Suicidal Thoughts	Drug/Alcohol Use	Anger/Hostility
Impulse Control	Anxiety	Headaches
Friendship Difficulties	Relaxation/Stress	Work Problems
Legal Matters	Motivation Problems	Tiredness/Fatigue
Body Image Issues	Loneliness	Concentration Difficulties
Attention Difficulties	Feelings of Inferiority	Temper
Career Choices	Nightmares	Health Problems
Issues Concerning Children	Guilt	Marital Problems
Appetite	Weight Issues	Parenting Issues
Grief/Loss	Shame	Memory
Spiritual Problems	Mood Swings	Adjusting to a Change
Other: _____		

**EDUCATIONAL HISTORY** (Dates, Programs, Degrees, Institutions)

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**RELEVANT WORK HISTORY** (Dates, Job title, Employer)

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**MEDICAL HISTORY** (Current Medical Health Issues (Describe Diagnosis, Dates, Treatment))

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Current Medications	Dosage/Frequency	Prescribed by	Reason

**PREVIOUS HEALTH CONCERNS** (Describe Diagnosis, Dates, Treatment)

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**SOCIAL SUPPORT** (Partner, Family, Friends, Community)

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**ACTIVITIES/HOBBIES/INTERESTS**

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**ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ABOUT YOU?**

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