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PATIENT INTAKE FORM

General Information:

(If the new patient is a child/adolescent, parents please fill in the child's information)

Patient's Name: _____ Social Security Number: _____

Date of Birth: _____ Referred By: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Address: _____

Insurance Name: _____ Employer for Insurance: _____

Insurance ID#: _____ Group ID#: _____

Insurance Phone#: _____

Employer Name: _____ Job Title: _____

Employer Address: _____ Highest Education: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____

Family Information:

Partner/Spouse: _____ Age: _____

Occupation: _____ Relationship Status: close distant

Parent: _____ Age: _____

Occupation: _____ Relationship Status: close distant

Parent: _____ Age: _____

Occupation: _____ Relationship Status: close distant

Number of Siblings: _____ Age of Siblings: _____

Relationship Status: close distant

Number of Children: _____ Age of Children: _____

Relationship Status: close distant

Current Mental Health Issues:

Describe what brought you into treatment at this time:

Please check any of the symptoms/topics you are seeking assistance for at this time:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Lose of interest |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Distracted | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Fatigued | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Academic |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Phobia | <input type="checkbox"/> Compulsions | <input type="checkbox"/> Hostility |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Mania | <input type="checkbox"/> Arguing | <input type="checkbox"/> Tantrum |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Sadness | <input type="checkbox"/> Grief | <input type="checkbox"/> Overly Focused |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Problem Solving | <input type="checkbox"/> Frustration | <input type="checkbox"/> Assertiveness |
| <input type="checkbox"/> Control | <input type="checkbox"/> Tension | <input type="checkbox"/> Irritability | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Pessimistic | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Lose of control |
| <input type="checkbox"/> Flash backs | <input type="checkbox"/> Neg. body image | <input type="checkbox"/> Confidence | <input type="checkbox"/> Hyper-vigilance |
| <input type="checkbox"/> Disconnected | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Avoidance | <input type="checkbox"/> Pleasing Others | <input type="checkbox"/> Social Skills |
| <input type="checkbox"/> Disorganized | <input type="checkbox"/> Hyped up | <input type="checkbox"/> Always Late | <input type="checkbox"/> Defensiveness |
| <input type="checkbox"/> Poor judgement | <input type="checkbox"/> Worried | <input type="checkbox"/> Delusions | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Perfectionistic | <input type="checkbox"/> Unsatisfied | <input type="checkbox"/> Poor listener | <input type="checkbox"/> Disappointment |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Substance Use | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> Recent Death | <input type="checkbox"/> Life Change | <input type="checkbox"/> Medical Issues |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Parenting | <input type="checkbox"/> Work | <input type="checkbox"/> Obsessiveness |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Neglect | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Weight Changes |

Mental Health Treatment History:

Psychotherapist: _____ Phone: _____

Treatment type: _____ Start Date: _____ End Date: _____

Psychotherapist: _____ Phone: _____

Treatment type: _____ Start Date: _____ End Date: _____

Psychiatrist: _____ Phone: _____

Treatment type: _____ Start Date: _____ End Date: _____

Current Medications:

Type	Dosage	Purpose	Duration
_____	_____	_____	_____
_____	_____	_____	_____

Medical History:

Please list any significant illnesses you have received medical treatment for including surgeries and hospitalizations, as well as any present medical symptoms that are undiagnosed.

Please check any that apply to you currently or in the past:

- | | | | |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Concussion | <input type="checkbox"/> Amnesia |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Black Outs | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> High/Low Blood Pressure | | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Menopause | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> ALS | <input type="checkbox"/> MS |

Primary Care Physician: _____ Phone #: _____

Address: _____

Current Medications:

Type	Dosage	Purpose	Duration

History of Substance Use:

Please check any that apply to you currently or in the past:

- | | | | |
|--------------|----------------------------------|-------------------------------|---------------|
| Caffeine: | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Tobacco: | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| OTC/Herbal | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Alcohol | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Marijuana | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Cocaine | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Heroin | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Pain killers | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Meth. | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |
| Ecstasy | <input type="checkbox"/> Current | <input type="checkbox"/> Past | Amount: _____ |

AOD Treatment Program: _____ Phone #: _____

Address: _____

Treatment type: _____ Start Date: _____ End Date: _____

AOD Treatment Program: _____ Phone #: _____

Address: _____

Treatment type: _____ Start Date: _____ End Date: _____

Patient's Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____