Nicole DeRobertis, LCSW, LLC

Initial Intake Form

Name: _____

Date: _____

History of Present Problem

How long ago did the problem(s) begin:

Please describe the problems that you would like help with:

Prior Treatment

Have you received therapy in the past? Yes No
From who?

When?
For what problems(s)?

Have you received psychiatric medication(s) in the past? Yes No

From who?

For what problems(s)? _____
Do you currently have a medication provider? Yes No

Who?

List all current psychiatric medications and dosages (medications that you are taking now):

List all past psychiatric medications and dosages (medications that you have taken but are no longer taking):

Have you even been hospitalized for psychological problems? Yes No

When?

Where were you hospitalized?

Psychiatric History

Place a check for each symptom that applies.

	Suicidal thoughts		Rapid mood changes
	Self-injury		Aggressive
	Emotional		Decreased need for sleep
	Shy and withdrawn		Racing thoughts
	Homicidal thoughts		Euphoria (feel on top of the world)
	Loss of interest in almost all activities		Risk-taking
	Feelings of hopelessness		Is very fidgety
	Apathy		Sexually inappropriate behavior
	Difficulty sleeping		Visual or auditory hallucinations
	Fatigue		Bizarre behavior
	Unmotivated		Sexual problems
	Poor self esteem		Overeating
	Quiet		Anorexia or Bulimia
	Feeling worthless		Stomach aches
	Depression/sadness		Concerns with physical problems
	Loss of appetite		Destroys other people's property
	Weight loss		Cruel to other people
	Anxiety/nervousness		Fire setting
	Recurrent/intrusive thoughts		Cruel to animals
	Excessive fears or phobias		Starts fights with others
	Rigid/inflexible		Breaks into other people's property
	Nightmares		When fighting, has used a weapon
	Explosive anger		Poor frustration tolerance
	Recurrent/intrusive disturbing recollections or dreams		Overwhelming need to perform certain behavior/rituals

Please describe any other symptoms you are experiencing not listed above:

Life Stress

Indicate which stressors you have experienced currently (within last 6 months) or in the past.

Now	Past		Now	Past	
		Death of a family member			Change in residence
		Illness of family member			Legal problems
		Illness of a friend			Work difficulties
		Personal injury/illness			Involved in accident
		Separated from spouse			Verbal/emotional abuse
		Divorce from spouse			Sexual assault
		Conflicts with family			Physical abuse
		Conflicts with friends			Other problems
		Conflicts at work			

Please describe the current stressors you are experiencing and how you feel they have impacted your overall functioning (psychological, health, work/school, relationships, leisure, etc):

Drug Screen

	Past	Current	Current Amount
Tobacco			
Marijuana			
Barbiturates (“Downers”)			
Tranquilizers			
Amphetamines (“Speed”)			
Crank			
Crack			
Cocaine			
Opiates (Heroine, Opium, Codeine, etc.)			
Hallucinogenics (LSD, STP, “Magic Mushrooms”, etc.) PCP (“angel dust”)			
Other:			

Please describe any previous and/or current treatment, self-help groups (AA, NA, Al-Anon, CODA) and/or any additional support utilized to maintain sobriety:

Longest period of sobriety (when was this?):

Medical History

Please circle all the conditions that have been diagnosed:

AIDS, ARC or HIV+	Abscessed ears	Allergies
Arthritis	Arteriosclerosis	Asthma
Bleeding disorder	Blood disorder	Broken bones
Brain disease	Cancer	Carbon monoxide poisoning
Colds (excessive)	Cerebral Palsy	Chicken Pox
Diabetes	Ear Infections	Encephalitis
Enzyme Deficiency	Fevers (>104)	Head injury/concussion
Heart problems	Hereditary disorder	Huntington's disease
Headaches	Hearing problems	Genetic disorder
Hypertension	Hormone problems	Hazardous substance expo.
Jaundice	Kidney problems	Immune system disorder
Leukemia	Lead poisoning	Liver disorder
Lung disease	Meningitis	Metabolic disorder
Measles	Mumps	Malnutrition
Multiple Sclerosis	Oxygen deprivation	Pneumonia
Polio	Parkinson's disease	Poisoning
Rheumatic fever	Radiation exposure	Scarlet fever
Stroke (Dementia)	Stroke or TIA	Tumor
Thyroid disease	Tuberculosis	Venereal disease
Vision problems	Whooping cough	Other medical problems

Have you ever been diagnosed with epilepsy or a seizure disorder ?

Yes No

List any medications currently being taken (over-the-counter or prescription), and the dosage.

1)

2)

3)

4)

5)

List any medications you are ALLERGIC or sensitive to:

Past Hospitalizations (When, where and for what):

Outpatient Surgeries (When, where and for what):

Name of family physician:

Address:

Phone:

Date of your last medical check-up:

Educational History

Current grade (Or highest grade/degree completed):

Learning problems (what subjects):

Special education placement (Type):

During which grades:

Extracurricular activities (Music, Sports, Clubs, etc.):

Expulsions/suspensions/conduct problems (Type of problem and date):

Additional schooling or non-academic training:

Occupational History

Present employer:

Position:

Length of employment:

Hours worked per week:

Current responsibilities:

List previous employment (Include dates and type of work):

Legal History

Present legal problems (Describe):

Past arrests (For what?):

Convictions (For what?):

Time served in juvenile hall, jail or prison (Give dates and locations):

Please write down any other information you would like to discuss that may not be listed elsewhere: