M. Elicia Nademin, Ph.D.

PRIVATE & CONFIDENTIAL - CLIENT INTAKE FORM

Your thorough and accurate completion of this form will provide a comprehensive picture of your background, what brings you in, and how we may best work together to meet your needs and goals. Information provided here will be treated with the same degree of confidentiality as anything you share with me when we meet. Please feel free to skip questions you prefer not to answer. If you run out of room for any item, please use the final section of the form designated for additional notes. In gray shaded areas, please select appropriate responses from the options listed. Please do not write in blue shaded areas designated for office use. Many thanks & WELCOME!

Name______________________________ **Today's date** ______________
(Last, First, Middle)

Birth date _____-____-_______ **Age**______ **Gender: M / F** **Client SS#** ______-______-__________

Ethnicity (Optional) ______________________ **Religion (Optional)** ______________________

Primary Language:____________________ **Secondary Lang:** ______________________

Address______________________ **City**______________**State**____**Zip**________

Marital Status: ____Married ____Re-Married ____Single ____In Relationship ____Divorced ____Widowed ____Separated ___# of Yrs

Highest level of Education (Circle): 1-8 9 10 11 12 GED Some College AA BA/BS Master's Doctorate Year? ____

(Please indicate preferred method of contact with an X): ( ) Home Phone (_____)______________ ( ) Work (_____)______________

( ) Cell (_____)______________( ) Email: ______________________*(confidentiality not guaranteed electronically)*

May I leave messages at each of the above? Y / N If no, please clarify: ______________________

***Billing/Responsible Party (if Different from Above)*: Name :** ______________________

Address______________________**City**______________**State**___ **Zip**__________

Preferred Method of Payment: ( ) Cash ( ) Check

Contact person in case of emergency: ______________________**Relationship**______________

Telephone (_____) ______________________ **Other Telephone** (_____) ______________________

Do I have permission to contact this person in the event of an emergency?* **Y / N *Please initial here*: ____________

Give a brief account of the history and development of the problems that bring you in today: ______________________

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____

What precipitated this specific visit? Why now? When did you first know there was an issue?______________________

____

____

***Circle any that apply to you*:**

Depressed mood * loss of interest or pleasure in usual activities * anxiety * panic * increased/decreased appetite * weight gain/loss * fatigue / low energy * nightmares * restlessness * feelings of loneliness * shy * feelings of emptiness * thoughts of death * difficulty decision-making * difficulty concentrating * guilt * feelings of worthlessness * irritability * sexual problems * can't keep a job * feelings of inferiority * work/school problems * difficult home conditions * financial problems * relationship problems * family problems

Sleep (past month): ☐ No problems ☐ Too Much Sleep ☐ Not Enough Sleep / # Hours per night: ___ # Hours per day: ___

☐ **Trouble falling asleep due to:** ☐ pain ☐ thoughts ☐ excessive energy ☐ environment (e.g., noise/light) ☐ Don't Know
☐ **Trouble staying asleep due to:** ☐ pain ☐ urinary frequency ☐ restlessness ☐ environment (e.g., noise/light) ☐ Don't Know
☐ **Early awakening due to:** ☐ pain ☐ urinary frequency ☐ restlessness ☐ environment (e.g., noise/light) ☐ Don't Know

How strongly do you want treatment? Very strongly! Somewhat I could do without it, if necessary I really don't want help

EDUCATION & OCCUPATIONAL HISTORY

What grades did/do you receive in school? ____

Ever been in special education classes? **Y / N** If yes, for which subject(s)?: ______________________________

How much effort did you put into school work? A LOT SOME Not Very Much Almost None

What is your current job title? _______________________________ How many hours/wk do you work?__________

How long have you been at this agency? ____________ If unemployed, list reason: ___________________________

How satisfied are you at work? **__ Very __ Somewhat __ Not** At what age did you begin working? __________

Please list last 3 jobs held (from most to least recent), length of time at each, & reason for leaving: _______________

____

____

What are you future occupational plans?____

(OFFICE USE ONLY): ____

____

FAMILY DATA

Where were you born? ___________________________ **And raised?** ____________________

Did your biological parents raise you? **Y / N** If No, who did and during what years?_______________________

Is your father still living? **Y / N** If yes, how is his health? Excellent Good Fair Poor

Occupation: ____ How often do you talk/meet? _______________

Describe his personality & attitude toward you:____

If deceased, state cause & year/age at time of death: ________________________

Is your mother still living? **Y / N** If yes, how is her health? Excellent Good Fair Poor

Occupation: ____ How often do you talk/meet? _______________

Describe her personality & attitude toward you:____

If deceased, state cause & year/age at time of death: ________________________

Are your biological parents still married? **Y / N** If not, how old were you when they divorced? ___________

If you have a step-parent, how old were you when your natural parent(s) remarried? ___________

How is your relationship with your step-parent(s)*:* **Great Good & Bad Not bad Poor**

If you have siblings, list names, ages, gender, jobs, & marital status of each, indicating step- or half-siblings: ____________

____

____

Describe your relationship with your brothers and/or sisters: ____

____

How was the atmosphere in your childhood home? Please note degree of compatibility between parents and between parents and children: ____

____

____

Were you able to confide in your parents? **Y / N** Siblings? **Y / N** If no, why? ___________________________

What forms of discipline were used in your home?____

If there is anything else you'd like to share about your upbringing, please do so here or on last page: ______________

____

____

(OFFICE USE ONLY): ____

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____

Relationship History

How satisfied are you with your current relationship status (e.g., single, married, divorced)? __ **Very** __ **Somewhat** __**Not**

Are you currently in a committed romantic relationship? **Y / N** **If yes, h**ow long have you known your partner? ___________

Spouse/Partner's personality: ____

In what areas are you compatible? ____

In what areas are you incompatible? ____

Describe any areas of conflict with your partner: ____

____

If married, how long were you engaged? _____________________ When were you married? _____________

Current Spouse's/Partner's Name: _______________________________ Age: ___ Occupation: _____________

How is your relationship with your in-laws: **Great** **Good & Bad** **Not bad** **Not well**

Were you married before? **Y / N** If yes, please list year(s) of prior marriage, divorce, & reason(s) for divorce: ____________

____

____

____

*** ******** ***

Do you have children? **Y / N** If yes, please list names, ages, sex, and brief description of each child's personality. Indicate if any of the children are from a previous marriage. Please include miscarriages, if any:_____________________________

____

____

Describe any areas of conflict with your children: ____

Sexual History

What were your parental attitudes toward sex (e.g., was there sex instruction or discussion in the home?)_____________

____

When & how did you derive your first knowledge of sex? ____________________________________

When & how were you first aware of your sexual impulses? _________________________________

Are you current sexually active? **Y / N** **If yes, how many days/month do you have sex?** _____

If you care to share additional information about heterosexual/homosexual relationships you have had, please list here:

____

____

____

(Office Use Only): ____

____

____

Social History

Do You Live in a House, Hotel, Aptartment, Condo, Other? ____________ Do you Rent or Own?

With Whom Do You Live?____

Do you make friends easily? **Y / N** If no, what do you think is the problem? ____________________

Do you tend to keep friends? **Y / N** How often do you spend time with friends?_________________

What kinds of things do you do with friends? ____

How is most of your free time occupied? ____

Did you experience disciplinary problems in school? **Y / N** If yes, please explain: _______________________

____

(Office Use Only): ____

____

____

Medical History

Please list any complications you may have incurred during birth and/or delays during your development (such as with crawling/walking/talking)? ____________________

Please provide the following information about your general health history.

Please Circle P for personal health history. Circle F for areas of family history.

P F Alcoholism/Illicit Drug use
P F Allergies: pollen, dust, animals, medications
P F Asthma, Bronchitis
P F Arthritis, Gout
P F Anxiety
P F Eating disorder: anorexia, bulimia
P F Bone/joint condition
P F Back, neck, spine, disc problem/injury
P F Birth defects/ Deformity
P F Blood disease: anemia, leukemia
P F Blood vessel, circulation disorder
P F Breast implants (L/R)
P F Broken bones/ bone disease
P F Cancer of any type
P F Diabetes
P F Ear/Nose/Throat disease or infection
P F Epilepsy/seizure disorder, convulsions
P F Fainting
P F Hysterectomy
P F Female organ irregularity, abnormal Pap, menstrual
P F Gallbladder
P F Heart problem or condition`
P F Hepatitis/liver disorder
P F Hernia
P F HIV/Aids
P F Hypertension; blood pressure disorder
P F Hormonal/Thyroid /Pituitary disorder
P F Immune system disorder, Lupus
P F Intestinal disorders
P F Kidney/Urinary tract infection/bowel disorder
P F Lung condition or infection
P F Male organ irregularity: prostate, impotence
P F Mental illness (e.g., depression)
P F Migraines/Headaches
P F Muscle/Tendon disorders
P F Nervous system conditions
P F Prosthetic implant/artificial limb
P F Reconstructive/Cosmetic surgery
P F Sexually transmitted diseases
P F Skin disorders/lesions/cancer
P F Steroid use: Prednisone
P F Stomach/ colon/ Crohn's disease
P F Stroke
P F Suicide
P F Tumors, cysts, polyps, growths
P F Ulcers, digestive disorders
P F Weight problems
P F Other, explain ____________

How was your health during childhood/adolescence: **Excellent Good Fair Poor**

How is your current physical health: **Excellent Good Fair Poor** ***If female***, are you/could you be pregnant? **Y / N**

How is your vision? Good Good With Correction (Glasses/Contacts) Poor Height: _______ Weight: _____

Do you or have you had: Speech difficulties? **Y/N** If yes, describe:____________________

Hearing difficulties? **Y/N** If yes, describe:____________________

Motor difficulties? **Y/N** If yes, describe:____________________

Any allergies? **Y/N** If yes, describe:____________________

Have you ever had surgery? **Y /N** If yes, please list type of surgery, when, where, why, & any complications: ____________

____

____

Please check if you have experienced any of the following conditions:

[ ] Head Injury [ ] Loss of consciousness/concussion [ ] Seizures [ ] convulsions [ ] other neurological diagnosis

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Family Physician / Name: ____________________**Phone (**______**)** ________________

Release of Information: "I give Dr. Nademin permission to contact my doctor regarding health issues relevant to my ongoing treatment, as necessary. I understand that this information will remain confidential."

____________________ (**Signature, Date**)

Mental Health History

Have you been in therapy before? (Please list all persons seen, when, for what, & for how long each time): ______________

____

____

____

Have you ever been hospitalized for mental illness? **Y / N** If yes, for what, when, where, and for how long? ______________

____

Please list past events that have profoundly affected you (e.g., serious car accidents; violence): ____________________

____

If any, do you have flashbacks/nightmares of these incidents? **Y / N** ____________________

____

Is there a history of family mental illness (e.g., depression, suicide, substance abuse, schizophrenia)? **Y / N / DK**

If yes, please list issue(s) & whether treatment was received:____________________

____

Do you or have you taken medications for emotional/behavioral issues (e.g., anxiety, depression, sleep)? **Y /N**

If yes, Please list medication, indicate time of use and whether you benefitted: ____________________

____

(Office Use Only): ____________________

Substance Use & Legal History

Do you smoke cigarettes? ___ **Yes** ___ **No** If no, h**ave you ever smoked cigarettes & stopped?** ___ **Yes** ___ **No**

If Yes to either, a) **How many cigarettes per day?** ___________

b) For h**ow many years?** ___________

c) **If you quit, when?** ________ How did you quit? ______________________________

Please indicate history and frequency of substance use:

	Current	Past		Current	Past
Alcohol			Hypnotics		
Tobacco			Diet Pills		
Caffeine (tea, coffee, Soda)			Narcotics / Pain		
Cocaine			Nerve Pills		
Marijuana			Sleeping pills		
Stimulants			Others (specify)		

Have you ever had a problem with (or received treatment for) alcohol or other drug use? Y /N

If yes, please explain:____

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Have you ever served in the military? **Y / N** Have you ever been arrested? **Y /N** If yes, were you convicted? **Y /N**

If convicted, what was the charge? ______________________________Have you ever served jail time? **Y / N**

Are you currently or have you ever been involved in a lawsuit? **Y /N** If yes, please explain: ______________

____

(Office Use Only): ____

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Timing

Why did you choose to come for treatment NOW? ____

____

How stressful has your life been <u>during the past 6 months?</u> *<u>(Circle one)</u>*

I've had NO stress **Much less stressful than usual** **Less stressful than usual**

Average level of stress **More stressful than usual** **Much more stressful than usual**

Please circle Yes or No to indicate (current) <u>greater than usual stress</u> in the following areas:

- Work: **Yes No**
- Health: **Yes No**
- Relationship with spouse/significant other: **Yes No**
- Activities related to your children: **Yes No**
- Activities related to your parents: **Yes No**
- Legal/financial trouble: **Yes No**
- School: **Yes No**
- Moving: **Yes No**
- Other:____

Briefly explain any items above to which you responded "Yes:"______________________________

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Are you planning major life changes (i.e., new job, moving, relationship, etc.) in the next 6 months? **Y / N**

If yes, please specify: ____

(Office Use Only): ____

____

____

Self-Portrait

Please provide a word or two that the following persons would describe you as:

a) Your spouse, lover, fiancée, partner______________________________

b) Your best friend______________________________

c) Your worst enemy (or someone who dislikes you)______________________________

d) Yourself______________________________

Resilience factors

When did you last feel both physically and emotionally healthy for a sustained period of time? ______________________________

____

Who are the most significant people in your life? ______________________________

____

Who is your biggest supporter? ______________________________

What were your hobbies/interests as a child? ______________________________

What are your current hobbies/interests?______________________________

Please list **5** goals you have for the future? ______________________________

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Please provide any additional details you wish to share here:______________________________

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(Office Use Only): ______________________________

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MEDICATION LIST

PATIENT NAME________________________ M F DOB____________ WT___________

PHARMACY: NAME__________________________ PHONE____________________________

ALLERGIES____
____

PLEASE LIST ALL MEDICATIONS YOU CURRENTLY TAKE OR HAVE TAKEN IN THE PAST 3 MONTHS

MEDICATION	REASON FOR USE	START DATE	DOSAGE	FREQUENCY	SIDE-EFFECTS

COMPLIANCE NOTES ____
____
____
____
____
____

M. Elicia Nademin, Ph.D.

CREDIT CARD AUTHORIZATION AGREEMENT

As the credit card holder, I, ____, hereby authorize Dr. M. Elicia Nademin to charge my credit card account for present and future purchases, verbally approved by me, as follows:

Credit Card Information:

Type of Credit Card: _____Visa _____MasterCard _____Discover

Credit Card Number: ____

Expiration Date: __________/_____ CVV2 Code (last 3 digits on signature panel): _________________

Name as it Appears on Card: ____

Credit Card Billing Address:

Street/Apt.: ____

City:____ State: ___________________

Zip Code: ________________ - _________ Country: (if not US) _________________________________

Telephone: ( ) ________ - _______________________

I understand that Dr. Nademin will keep all information entered on this form strictly confidential and that I may revoke this authorization in writing at anytime for transactions applied after said revocation.

This Credit Card Authorization is Valid Until:

Initials Here: _____ Treatment is terminated with Dr. Nademin

Initials Here: _____ Other **(Specific Date)**: ____

Cardholder Signature: ____ Date: _________________

Cardholder Name Printed:____ Date: _________________