Private Practice Intake Paperwork for Psychological Services with Dr. Chantelle Pseekos

Name: _____ Date: _____

Social Security Number: _____ Date of Birth: _____

Residential Address: _____
_____

Preferred Phone Number: _____

Secondary Phone Number: _____

Email Address: _____

Preferred Security Question for Encrypted Email Messages:
_____
Answer to Security Question: _____

I consent to contact from Dr. Chantelle Pseekos through (check all that apply)____Email, ___Preferred Phone Number, ___Secondary Phone Number, ____Residential Address.

Signature:_____ **Date**:_____

Age: _____ Disability Status (Physical, Learning; if Applicable): _____

Gender/Gender Identity: _____

Racial Background/Identity: _____

Sexual Orientation/Identity: _____

Spiritual/Religious Identity: _____

Other Important Parts of Your Identity (Please Specify): _____

Employment Location Name/Profession (if Applicable/Please Specify Full or Part-Time):
_____

University/College Name/Major (if Applicable/Please Specify Full or Part-Time):
_____

Emergency Contact Name: _____
Emergency Contact Relationship to You/Phone Number: _____
_____

Current Symptoms/Areas of Concern (Please Check All that Apply/Specify How Long Each Symptom has Occurred in Days/Weeks/Years):

____Sleep Disruption How Long?_____

____Eating Disruption How Long?_____

____Reduced Concentration How Long?_____

____Distractibility How Long?_____

____Difficulty Adjusting to New Life Circumstances How Long?_____

____Panic Attacks How Long?_____

____Avoidance of Social Activities How Long?_____

____Anxiety (Lasting 1 Hour or More) How Long?_____

____Intrusive/Unwanted/Obsessive Thoughts How Long?_____

____Depression (Lasting 3 Days or More) How Long?_____

____Loss of Interest in Previously Enjoyed Activities How Long?_____

____Hopelessness How Long?_____

____Anger How Long?_____

____Aggression How Long?_____

____Irritability How Long?_____

____Extreme Mood Swings How Long?_____
(Do Not Check if Symptom Only Occurs with Family)

____Sexual Trauma/Violence How Long?_____

____Emotional/Psychological Trauma/Violence How Long?_____

____Physical Trauma/Violence How Long?_____

____Grief/Death of a Loved One How Long?_____

____Family Difficulties How Long?_____

____Challenges Understanding Yourself How Long?_____

____Impaired Social Relationships How Long?_____

____Impaired Romantic Relationships How Long?_____

____Impaired Work Functioning How Long?_____

____Impaired Academic Functioning How Long?_____

____Thoughts of Suicide How Long?_____

____Thoughts of Harming Others How Long?_____

____Self-Harm Behaviors How Long?_____

____Alcohol Use (4 or More Drinks in One Day/Evening) How Long?_____

____Non-Prescription Drug Use How Long?_____

____Lack of Attention to Details How Long?_____

____Risky Behavior How Long?_____

____Impulsivity How Long?_____

____Concerns Related to a Partner's Infidelity How Long?_____

____Divorce How Long?_____

____Sexual Difficulties How Long?_____

____Trust Difficulties How Long?_____

____Worries that Others May Leave You How Long?_____

____Physical Symptoms (e.g., Migraines, Stomach Upset) How Long?_____

____Seeing/Hearing Things Others Cannot How Long?_____

____Paranoia/Believing Others Monitor You How Long?_____

____Dissociative Experiences (e.g., Time Seems Lost) How Long?_____

____Other Areas of Concern (Please Specify)_____

Previous Symptoms/Past Areas of Concern (Please Check All that Used to Apply/Specify How Long Each Symptom Occurred in Days/Weeks/Years):

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____Eating Disruption How Long?_____

____Reduced Concentration How Long?_____

____Distractibility How Long?_____

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____Dissociative Experiences (e.g., Time Seems Lost) How Long?_____

____Other Areas of Concern (Please Specify)_____

Goals, Treatment History, Insurance Information, Personal Strengths

Primary Goal(s) for Psychological Services:_____
_____

Preferred Treatment Approach (e.g., Cognitive Behavioral, Mindfulness-Based, Emotion-Focused, etc., if Applicable):_____

Name of Primary Physician:_____

Name of Psychiatrist/Psychiatric Nurse (if Applicable):_____

List of All Medications (including Frequency/Dosage):_____
_____

Name of Any Previous Counselors/Psychologists/Psychiatrists/Other Mental Health Providers/Facilities (if Applicable):_____
_____

Dates/Duration of Previous Mental Health Treatment Services (if Applicable):_____
_____

Reason for Ending Previous Mental Health Treatment Services (if Applicable):_____
_____

Most Beneficial Part of Previous Mental Health Treatment Services (if Applicable):
_____

Least Beneficial Part of Previous Mental Health Treatment Services (if Applicable):
_____

I am Open to (Please Check All that Apply): _____Individual Counseling Services
_____Group Counseling Services _____Couples Counseling Services

Preferred Duration of Treatment (e.g., 3 months):_____

Insurance Information (if Applicable):_____

Interests/Hobbies:_____
_____

Personal Strengths/Areas that You/Others in Your Life View as Positives about You:
_____
_____

Referred By/Learned About this Private Practice Through:_____