SHELBY HARRIS, PSYD, PC
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INTAKE FORM

DEMOGRAPHICS

Name _____
(First) (Middle) (Last)

Home Address _____
(Street)

_____
(City) (State) (Apt/Suite) (Zip)

Telephone: (Home) _____ (Work) _____

(Cell) _____ Occupation: _____

Date of Birth _____ E-mail Address _____

EMERGENCY CONTACT

_____
(Name) (Relationship to you)

Telephone: (Home) _____ (Cell) _____

Does this person know that you are seeing a psychologist? YES ☐ NO ☐

REFERRAL SOURCE

___Doctor Name: _____
___Friend/Relative Name: _____
___Website Specify: _____
___Other Specify: _____

REASON FOR REFERRAL

Please describe why you are seeking treatment/what issues you would like help with:

BACKGROUND/FAMILY INFORMATION

Education Level: _____

Relationship Status (circle one):

Single *Dating* *Long-term relationship (not living together)*

Married/domestic partner *Separated* *Divorced* *Widower* *Other*

Please list all individuals who are currently living with you:

Name	Relationship to You	Age

If you have children who are not living with you, write down the following information:

Child's name	Child's Age	Where Child Resides

MEDICAL HISTORY

Please list your medical problems (past and current):

Please list medical hospitalizations/surgeries:

Dates Reason for Hospitalization/surgery

Please list all *current* medications and supplements taken for ***medical and psychiatric*** issues (include dosages):

PSYCHOLOGICAL TREATMENTS

Are you currently receiving mental health services of any kind? YES ☐ NO ☐

If yes, please provide the name, address and phone number for your current therapist:

If applicable, please write the name and phone number of the doctors who prescribes *current* psychiatric and/or sleep medications:

Please list all previous mental health services (including, but not limited to, psychiatry, psychology and social worker services) received below in chronological order:

Mode of Treatment (individual, group, family, other)	Dates	Provider	Reason for Treatment

Psychiatric Hospitalizations (please provide information, dates, reason for hospitalization):

What (if any) psychiatric or sleep medications have you tried in the past? Why did you stop?

Please circle the issues for which you are currently seeking help (circle all that apply):

Anxiety	Regrets	Low energy	Sexual Problems
Depression	Mood Swings	Sleepiness	Irritable Bowel
Insomnia	Irritability	Procrastination	Physical Complaints
Nightmares	Relationship/Marital Issues	Shyness	Decision-Making
Problems using CPAP	Stress	Hopelessness	Body Image
Narcolepsy	Suicidality	Inactivity	Overweight
Anger	Assertiveness	Job/Career Concerns	Underweight
Obsessive Thoughts	Loneliness	Problem-Solving	Binge Eating
Panic	Self-Criticsm	Fears	Alcohol/Substance Abuse
Self-Esteem	Meeting people	Friendships	Implusivity
		Social Skills	

Please use this space to describe any other problems, questions or concerns you would like me to know about.

ISI

1. Please rate the current (i.e., last 2 weeks) severity of your insomnia problem(s) (circle your answers).

	None	Mild	Moderate	Severe	Very
a. Difficulty falling asleep	0	1	2	3	4
b. Difficulty Staying asleep	0	1	2	3	4
c. Problem waking up too early	0	1	2	3	4

2. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
0	1	2	3	4

3. To what extent do you consider your sleep problem to interfere with your daily functioning (circle one)? (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.):

Not at all interfering	A little	Somewhat	Much	Very much interfering
0	1	2	3	4

4. How noticeable to others do you think your sleeping problem is in terms of impairing the quality of your life (circle one)?

Not at all noticeable	A little	Somewhat	Much	Very much noticeable
0	1	2	3	4

5. How worried/distressed are you about your current sleep problem (circle one)?

Not at all worried	A little	Somewhat	Much	Very much worried
0	1	2	3	4

PHQ9/GAD7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things……..	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless……...	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much…	☐	☐	☐	☐
d. Feeling tired or having little energy……..	☐	☐	☐	☐
e. Poor appetite or overeating……	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down……...	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television…….	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual? …….	☐	☐	☐	☐
i. Thoughts that you would be better off dead or hurting yourself in some way…….…….	☐	☐	☐	☐

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Feeling nervous, anxious or on edge	☐	☐	☐	☐
b. Not being able to stop or control worrying.	☐	☐	☐	☐
c. Worrying too much about different things.	☐	☐	☐	☐
d. Trouble relaxing.	☐	☐	☐	☐
e. Being so restless that it is hard to sit still.	☐	☐	☐	☐
f. Becoming easily annoyed or irritable.	☐	☐	☐	☐
g. Feeling afraid as if something awful might happen.	☐	☐	☐	☐

AUTHORIZATION TO **RECEIVE** AND **RELEASE** INFORMATION FROM PRIMARY CARE PHYSICIAN, PSYCHIATRIST AND ANY OTHER RELEVANT TREATMENT PROVIDERS

SHELBY HARRIS, PSYD, PC

DATE: _____

I, _____, authorize Dr. Shelby Harris to discuss my information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: _____Affiliation: _____

Address:_____

Phone Number:_____

2. Name: _____Affiliation: _____

Address:_____

Phone Number:_____

3. Name: _____Affiliation: _____

Address:_____

Phone Number:_____

I understand this authorization will expire at the end of treatment or at any time prior upon written request.

I hereby consent that this communication can take place through (check all that apply):

_____*telephone* _____*fax* _____*email* _____*mail*

Date: _____

Name of Patient (Print): _____

Signature of Patient: _____

(if necessary) Authorized Representative's Relation to Patient:

_____