McClellan & Associates
14751 Plaza Dr., Suite F Tustin, CA 92780
Work (949) 359-1353 Fax (714) 544-4472

Client General Information

Name_____

Date_____

Street_____City_____State_____Zip_____

Home (_____)_____Work (_____)_____ Cell (_____)_____

Email _____

Referred By: _____

The fee for counseling services is $ _____ per 55 minute session. This is to be rendered at time of service. Forty-eight hour cancellation is required to avoid being charged for the scheduled appointment. The purpose of our initial consultation is to determine your needs and to help you decide what form(s) of psychological consultation may be desirable and most beneficial for you.

Please read over and sign the Informed Consent form provided to you. Please feel free to ask any questions if something seems unclear or not completely understood.

Reason for seeking consultation:

_____

_____

_____

I have read and understood the above parameters for this consultation. I am 18 years or older, or the legal guardian of the person named above.

_____ _____
Signature Date

Intake Form

Please provide the following information and answer the questions below.
Please note: information you provide here is protected as confidential information.
Please fill out this form and bring it to your first session.

Name:

_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ **Age**: _____ **Gender:** □ Male □ Female

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children/age: _____

Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____May we leave a message? □ Yes □ No

Cell/Other Phone: (_____)_____May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____

Have you previously received any type of mental health services
(psychotherapy, psychiatric services, etc.)?
□ No
□ Yes (Previous therapist/practitioner): _____

Are you currently taking any prescription medication?
□ No
□ Yes (Please list): _____

Have you ever been prescribed psychiatric medication?

□ No

□ Yes (Please list and provide dates): _____

General Health & Mental Health Information

1. **How would you rate your current physical health?** (Please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific health problems you are currently experiencing:

   _____

2. **How would you rate your current sleeping habits?** (Please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific sleep problems you are currently experiencing:

   _____

3. **How many times per week do you generally exercise?_____**

   What types of exercise to you participate in: _____

4. **Please list any difficulties you experience with your appetite or eating patterns.**

   _____

5. **Are you currently experiencing overwhelming sadness, grief or depression?**

   □ No

   □ Yes (For approximately how long?) _____

6. **Are you currently experiencing anxiety, panic attacks or have any phobias?**

   □ No

   □ Yes (When did you begin experiencing this?) _____

7. **Are you currently experiencing any chronic pain?**

   □ No

   □ Yes (Please describe) _____

8. **Do you drink alcohol more than once a week?**

   □ No

   □ Yes

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship?

□ No

□ Yes (For how long)? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

_____

_____

Family Mental Health History

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1. Are you currently employed?

□ No

□ Yes (If yes) what is your current employment situation: _____

_____

2. Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

3. Do you consider yourself to be spiritual or religious?

□ No

□ Yes (If yes) describe your faith or belief: _____

_____

4. What do you consider to be some of your strengths?

_____

_____

5. What do you consider to be some of your weakness?

_____

_____

6. What would you like to accomplish out of your time in therapy?

_____

_____

_____