CONFIDENTIAL CLIENT INTAKE INFORMATION QUESTIONNAIRE

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Clinical Psychologist
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Name: _____ Age: _____ Birth date: _____/___/_____ Today's Date: _____/___/_____

Address: _____ Home phone: _____

Street or P.O. Box number City State Zip code

Email address where invoices may be sent: _____ Work phone: _____ Cell phone:_____

Emergency Contact Name and Phone Number: _____ _____

Birthplace: _____ Marital status: _____ # times married: _____ # yrs in current marriage: _____

Occupation: _____ Employer: _____ Education: _____

Spouse's name: _____ Employer: _____ Occupation: _____

Religion: _____ Who referred you? _____ Family doctor: _____

List any major health problems: _____

Please list any medications you take: _____

Have you been in therapy before? _____ If yes, when? _____ Problem? _____

Whom did you see? _____ Did it help? yes some no

How many children do you have? _____ Please list first names and ages: _____

(please circle the names of those currently living with you; if not with you, indicate where)

Please check or circle any of the following that are currently troubling you:

inferiority feelings	children	loneliness	headaches	phobias	tiredness
nervousness	shyness	education	insomnia	extreme fatigue	sadness
suicidal thoughts	separation	guilt	agoraphobia	panic attacks	sexual problems
making decisions	drug use/abuse	bowel trouble	appetite	overweight	fetishes
health problems	anger	depression	fears	sexual abuse	conflict
stomach trouble	sleep	divorce	finances	abused as a child	self-esteem
career choices	relaxation	alcohol use	friends	battered/beaten	homicidal
concentration	painful thoughts	compulsions	confidence	temper	no interests
being a parent	energy	self-control	unhappiness	ACOA	impotence
marriage	legal matters	ambition	stress	work	legal problems

Please describe briefly your reasons for seeking psychological consultation or therapy:

What do you hope to get out of this consultation?

_____

My signature below indicates that I have been given copies of Dr. Fraser's Psychotherapy Service agreement and the HIPPA privacy practices form.

Signature: _____ SSN: _____

Date: _____

Please be aware that I request FULL payment at the time of each visit. If you have health insurance that covers "out-of-network" psychological services (also known as "behavioral health" services), it is your responsibility to contact your insurance provider to request what they require for possible reimbursement. I will be happy to provide you with whatever billing records are required for reimbursement. I currently charge $300.00 per 45-50 minute session. I generally operate very much on time so it will be to your advantage to arrive on time for your appointment. Your appointment time is reserved exclusively for you, and thus I do charge in full for uncancelled or missed appointments—if you must cancel, my policy is that you do so at least 48 hours prior to your appointment time to avoid being charged for the appointment. If you have questions about financial arrangements please bring them up. Thanks!