

RONALD ALEXANDER, Ph.D.
Psychotherapy
Licensed Marriage and Family Therapist MFC # 7707
Professional and Leadership Coaching

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INFORMATION FORM- PLEASE PRINT

TODAY'S DATE	E Mail Address (PLEASE PRINT)	

LAST NAME	FIRST NAME	SOCIAL SECURITY NO.

HOME PHONE	WORK PHONE	EXTENSION

DATE OF BIRTH	DRIVER LICENSE #	STATE

HOME ADDRESS		

CITY	STATE	ZIP

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)		

CITY	STATE	ZIP

REFERRED BY		

FAMILY PHYSICIAN	PHONE	

PHYSICIAN'S ADDRESS		

EMPLOYER'S NAME		

EMPLOYER'S ADDRESS		

CITY	STATE	ZIP

BANK NAME	ACCOUNT #	ACCOUNT TYPE

OFFICE USE

Page Two – Patient In-Take Form

1.) Marital Status/history _____

2.) What are your reasons for seeking counseling or psychotherapy at this time?

3.) Have you ever-received psychotherapy or counseling before? If so what was it for, how long, with whom and when did it end?

4.) Has any member of your family of origin or your extended family had any history of depression, anxiety, alcoholism, drug addiction, violence or emotional difficulties?

5.) Have you ever experienced or suffered from any form of abuse? If so please explain in detail.

6.) Have you ever received any treatment that included Hypnosis, Guided Imagery or EMDR or other system of psychotherapy for the specific treatment of abuse, trauma, and psychological or medical conditions?

7.) Have you ever been involved in litigation or made a complaint to a State Medical or Psychological Board or the Board of Behavioral Sciences or are you currently involved in any litigation or complaints against any mental health or medical practitioner? If so please explain.

8.) Are you experiencing any form of physical pain if so please describe?

9.) Have you ever experienced any violent or aggressive behavior towards self or others? Have you ever attempted to commit suicide? If so please explain.

Page Three – Client In-Take Form

10.) Are you struggling with any of the following issues: stress, sexual problems, work, family, relationship, sleep, self harm, eating disorder, harm towards others, parent/child, professional, drug – alcohol, family-child abuse, changes in physical health?

11.) Please list in detail any past or current medications that you are taking.

12.) Are you under the current care of a Psychiatrist or Medical Doctor for these medicines? If so name, address and phone number of the Doctor?

13.) My I have your permission to contact and consult with your Doctor?

14.) Who is your family Doctor or Internist? Please list name, address and phone number

15.) Have you ever been hospitalized for psychiatric reasons if yes where, when and how long?

16.) Have you ever or do you currently use recreational drugs. If yes what kinds and how often?

17.) What are you current skills, strengths, interests and joys in your personal and professional life. Where do you feel that you are thriving, winning or growing?

Client Name Printed Date Client Signature

Parent Name Printed Date Parent Signature
(If Client is a Minor)

Ronald A. Alexander Ph.D. Date
