

New Patient Intake Form

Please Note: This is an Interactive PDF Form. Please Complete and Click here to email to DrRon@RonaldAlexander.com

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Name: _____

Address: _____

If Married/Civil Union, Partner's Name: _____

Yrs. Married: _____

If Not Married (Check One): Separated, Widowed, Divorced, Single

Prior Marriages: From _____ to _____ Name: _____

From _____ to _____ Name: _____

Children: Name Age Name of other Parent

Where were you born? _____

Education: Highest grade completed or Degree _____

Previous therapy:

Year Length Therapist's Name City Problem

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

Religious Upbringing:
Religious Group: _____ Conservative or Reform (Check One)

Currently Practicing: _____ Location: _____

In case of emergency, please notify: _____

Address: _____

Phone: _____

Relation to you: _____

Reason for Consultation (Please describe in your own words):

Why are you seeking support at this particular time?

Recent Stresses (Please check if you have experienced any of the following in the past months):

- _____ Marriage or divorce of yourself or someone you are close to
- _____ Victim of physical or sexual assault
- _____ Moved to a new location
- _____ Financial crisis
- _____ Death of a relative or close friend
- _____ Arrested by law enforcement
- _____ Lost job; new job
- _____ Child moving from home or other parenting problems
- _____ Drug/alcohol
- _____ Serious decline in your health or someone close to you
- _____ Major accident or physical condition
- _____ Eating disorder
- _____ Harm towards others
- _____ Self harm
- _____ Sleep disorder
- _____ Sexual problems

Please describe your current medical condition: _____

Current Medications:

<u>Name of Drug</u>	<u>Dosage</u>	<u>Purpose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.

May I have your permission to contact and consult with your Doctor? YES ____ NO ____

If in physical pain, please explain:

Family Health History (Immediate and other relatives):

	<u>Who</u>	<u>Relationship to You</u>
___ Alcoholism	_____	_____
___ Drug Addictions	_____	_____
___ Anxiety	_____	_____
___ Suicide	_____	_____
___ Hospitalizations (Mental)	_____	_____
___ Chronic Physical Conditions	_____	_____
___ Physical or Emotional Abuse	_____	_____

How many hours do you sleep per night? _____

How is the quality of your sleep? _____

Do you have nightmares or recurrent dreams? (Please describe)

Are you now, or have you ever, experienced any of the following symptoms:

- | | | |
|-------------------|---------------------|---------------------------|
| ___ Sad | ___ Insomnia | ___ Lost interest/Friends |
| ___ Crying Spells | ___ Waking Early | ___ Lost interest/Sex |
| ___ Appetite Loss | ___ Excessive Sleep | ___ Easily Fatigued |

<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Feeling Hopeless	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Nervous/Jittery	<input type="checkbox"/> Low Concentration	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Tension	<input type="checkbox"/> Temper Outbursts
<input type="checkbox"/> Irritability	<input type="checkbox"/> Worrying	<input type="checkbox"/> Persistent Thoughts
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sweating	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Headaches	<input type="checkbox"/> Confusion	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Out of Body Exp.
<input type="checkbox"/> Change in Taste	<input type="checkbox"/> Visual Auras	<input type="checkbox"/> See Spots/Lights
<input type="checkbox"/> Personality Change	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hot/Cold Spells
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Marijuana Use	<input type="checkbox"/> Cocaine Use
<input type="checkbox"/> Stimulant Use	<input type="checkbox"/> Hallucinogen Use	<input type="checkbox"/> Other
<input type="checkbox"/> Non-prescription Narcotic	<input type="checkbox"/> Non-prescription Tranquilizer	

Have you ever experienced any violent or aggressive behavior towards self or others? Are you currently feeling suicidal? _____

Have you felt suicidal or attempted suicide in the past? (Explain circumstances)

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

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?

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

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

What are your 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
(If Client is a Minor)

Date

Parent Signature

Ronald A. Alexander Ph.D.

Date