Date:_____

Charles A. Schaefer, Ph.D., Inc.

919-357-7203 Charlie@CharlieSchaefer.com

Patient (Client) Name_____
Address_____
City_____State_____Zip_____
Age _____Date of Birth ____/____/_____ Gender: Male □ Female □
Home Phone _____ May I leave a message? Yes No
Cell Number _____ May I leave a message? Yes No
Work Number _____ May I leave a message? Yes No
E-mail _____ May I leave a message? Yes No

If Adult:
Name of Employer_____Occupation_____
Spouse/Partner's Name_____
Children's Names and Ages_____

If Student/Senior: Parent/Guardian's/POA's Name_____
Relationship _____ Best phone # to be reached at _____
School /College currently attending _____Grade/Year_____

In case of emergency notify:
Name_____ Relationship_____
Address_____ City_____ State _____ Zip_____
Work Phone_____ Home Phone_____ Cell Phone_____

Financial Guarantor Information (If other than self):
Name_____ Relationship _____
Address_____ City_____ State _____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____

Insurance Company:_____ID#_____Group#_____
Policyholder_____ Policyholder's Date of Birth_____
Claims Address_____City _____ State _____Zip _____
Employer _____Copay, if known_____

Primary Care Physician: _____
Address _____ City/State/Zip _____
Phone _____ Fax _____

Referral Source: How did you find out about us?
Friend □ Insurance Co. □ Medical Professional □ Pastor □ Employer □ Internet □ Other_____

Religion_____

Church Affiliation (if any)_____

Pastor_____ Do your current difficulties affect your spirituality? Yes □ No □

Would you like spiritual resources and discussion of spiritual topics based on your spiritual beliefs to be included as part of your psychotherapy, when they are applicable? Yes □ No □

Adult Intake Questionnaire

What is the primary reason you are seeking help at this time? _____

_____

_____

Please check all that apply below (if you have any questions about these, please ask your therapist):

[ ] Panicky feelings [ ] Fears [ ] Avoidance [ ] Procrastination [ ] Shyness [ ] Driven to perform certain behaviors
[ ] Nervous Tics [ ] Difficulties making decisions [ ] Flashbacks [ ] Nightmares [ ] Feeling unreal [ ] Mood swings
[ ] Anger problems [ ] Bingeing [ ] Purging [ ] Loneliness [ ] Disorganization [ ] Seasonal variations of mood
[ ] Mania [ ] Guilt [ ] No sense of purpose [ ] Spiritual or religious concerns [ ] Sensitivity to noise and lights
[ ] Relationship problems [ ] Sexual problems [ ] Suspicious of others [ ] Hearing unidentified sounds or voices

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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all	Some-what	Very difficult	Extremely difficult
In the past TWO years, have you felt depressed or sad most days, even if you felt okay sometimes?	Yes	No		Score:

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
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total Score:				

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:		
1. Have had nightmares about it or thought about it when you did not want to?	Yes	No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
3. Were constantly on guard, watchful, or easily startled?	Yes	No
4. Felt numb or detached from others, activities, or your surroundings?	Yes	No

Mental Health History

Has anyone in your family had any of the following conditions? (check all that apply)

☐ Depression ☐ Anxiety ☐ Suicide ☐ Bipolar Disorder ☐ Psychosis ☐ Alcoholism ☐ Substance Abuse

If yes, please describe the family member's relationship to you and the problem:

Concern_____ Which relatives_____

Concern_____ Which relatives_____

Concern_____ Which relatives_____

Have you ever wanted to end your life? ☐ No ☐ Yes Have you ever attempted suicide? ☐ No ☐ Yes

Do you currently have suicidal thoughts? ☐ No ☐ Yes Have you tried to harm yourself recently? ☐ No ☐ Yes

Do you ever feel angry enough or out-of-control enough to do something you might regret? ☐ No ☐Yes

Do you have now or have you ever had thoughts of killing or seriously hurting someone else? ☐ No ☐ Yes

In the past year, have you slapped, kicked, punched, or hurt anyone? ☐ No ☐ Yes

Childhood History

As a child did you have any problems with:			**Age**
☐Learning disabilities	☐ No	☐ Yes	_____
☐Hyperactivity	☐ No	☐ Yes	_____
☐School fears	☐ No	☐ Yes	_____
☐Depression	☐ No	☐ Yes	_____
☐Sexual or physical abuse	☐ No	☐ Yes	_____

Any there other major childhood (0-17 years) school, learning, or emotional problems? ☐ No ☐ Yes

If yes, please describe: _____

Personal History

Which of the following best describes the family in which you grew up?

Warm and Accepting Average Distant, Hostile, and Fighting

1 2 3 4 5 6 7 8 9

Was your family/home/or adult life disrupted by serious illness/accident/death/divorce?

☐ No ☐ Yes If yes, please describe _____

_____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Number of years married: ____Total number of marriages: ____ Spouse/Partner's name: _____

Do you have any children? ☐ No ☐ Yes If yes, what are their names and ages? _____

_____

How satisfied are you with your current family life? ☐ Very Unsatisfied ☐ Unsatisfied ☐ Satisfied ☐ Very Satisfied

How satisfied are you with the support you currently receive from your family and friends?

☐ Very Unsatisfied ☐ Unsatisfied ☐ Satisfied ☐ Very Satisfied

Have your current difficulties affected your family/friends/coworkers? ☐ No ☐ Yes

Previous Counseling or Chemical Dependency Services:

Have you ever seen anyone or are you currently seeing anyone for:

Individual Therapy	☐ No	☐ Yes	Marital/Couples Therapy	☐ N o	☐ Yes
Group Psychotherapy	☐ No	☐ Yes	Sex Therapy	☐ No	☐ Yes.

Facility/Counselor Name	Month/Year Seen	Reason Seen	Helpful?
_____	_____	_____	☐ No ☐ Yes
_____	_____	_____	☐ No ☐ Yes

Have you experienced any unusually severe stresses during the past year? □ No □ Yes
If yes, please describe: _____
_____
_____

Job Satisfaction: □ Very Satisfied □ Fairly Satisfied □ Not Satisfied
What is your job/profession?_____ Highest Degree Completed _____
Have you ever taken work leave for mental health or chemical dependency problems? □ No □ Yes
Do you have problems with your work performance or boss? □ No □ Yes

Medical/Lifestyle History

Current health □ Poor □ Fair □ Good □ Excellent
Do you have any medical problems or diseases? _____
_____
_____
Did you ever have a head injury? □ Yes □ No Did you ever have a seizure? □ Yes □ No
If yes, please describe _____
Do you exercise regularly? □ Yes □ No If yes, how many times per week? _____

Medications currently used:

Medication/Dose	When Prescribed	Why Prescribed	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take any herbal medications? □ No □ Yes Please name _____

Past Hospitalizations (Psychiatric/Chemical Dependency)

Date(s)	Reasons	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol use
How often do you use alcohol? □ None □ Monthly □ Weekly □ Daily □ Other _____
On the days that you drink, how many drinks do you usually have?
□ Less than 2 □ 2-5 □ 5 or more
Do you consider it a problem? □ No □ Yes Do others consider it a problem? □ No □ Yes
Do you have problems at work/school because of drinking or drug use? □ No □ Yes
Have you had problems with alcohol in the past? □ No □ Yes

Nicotine use
Do you smoke or use tobacco now? □ No □ Yes, how much/day? _____
Have you smoked or used tobacco in the past? □ No □ Yes

Caffeine
How many cups of caffeinated coffee/tea/soft drinks do you drink per day? _____

Drug use
Marijuana: □ None □ Occasionally □ Daily □ Weekly
Do you use other non-prescription substances? □ No □ Yes If yes, what substance?_____

Legal History: □ None □ Litigation □ Arrest □ Victimization, specify _____
Are you presently involved in a court case? □ No □ Yes

THERAPIST-CLIENT SERVICES AGREEMENT
CHARLES A. SCHAEFER, PH.D., INC.

I. I have received a copy of the Charles A. Schaefer, Ph.D., Inc. THERAPIST-CLIENT SERVICES AGREEMENT and a copy of the Charles A. Schaefer, Ph.D., Inc. PRIVACY NOTICE. (These forms are available on the practice website at www.CharlieSchaefer.com.)

_____
Initials/ Date

II. ***(This must be initialed and signed by your first session.)***

I have read, understand, and accept the following by initialing each item:

_____ that Charles A. Schaefer, Ph. D., Inc. may disclose Protected Health Information as necessary to my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must pay in full for services.

_____ that Charles A. Schaefer, Ph.D., Inc. may use Protected Health Information within the practice for the purpose of Treatment/Consultation

_____ that Charles A. Schaefer, Ph.D., Inc. may share Information as necessary with my primary care physician. If you do not wish information to be shared with your physician initial the "no" block below.

____ NO, do not share information with my physician

Please initial the following if Charles A. Schaefer, PhD., Inc. staff:

_____ may contact you or leave messages at your **home** telephone number

_____ may contact you or leave messages at your **work** telephone number

_____ may contact you or leave messages at your **cell phone** telephone number

_____ may contact you by **e-mail.** If yes, specify address_____

I have read, understand, and accept all of the provisions of the Charles A. Schaefer, Ph.D., Inc. THERAPIST-CLIENT SERVICES AGREEMENT and the Charles A. Schaefer, Ph.D., Inc. PRIVACY NOTICE.

_____ _____
Name (Patient/Client or Representative) Date

_____
Relationship to Patient/Client