MARIE MARGENAU-SPATZ, Ph.D.

Patient Intake Information

Strictly Confidential

Thank you in advance for completing this Intake form. Please answer the information requested, print clearly and answer all sections completely.

Section I.

Intake Date: (Month / Day / Year)

Patient Name & Address & Telephone:

Last: First: Middle: Preferred Name:

Address: Apartment / Suite Number:

City/State/Zip:

Telephone: Day/Work: ( ) Eve/Home: ( ) Fax: ( )

Mobile: ( ) Vacation Phone: ( ) Email:

Emergency Notification:

Name: Relationship:

Telephone:

Bill To: (If someone other than you is responsible for payment)

Name: Relationship to Patient: Telephone:

Address: Apartment / Suite Number:

City/State/Zip:

Referral Source:

Name:

Relationship to Patient:

Treatment/Service: (Please leave blank)

90806 ☐ 90808 ☐ 90847 ☐

Diagnosis: (Please leave blank)

I. II.

III. V.

Date of Birth: **Present Age:** **Social Security #:**

Occupation:

Employment: Please ☑ check one: Self-Employed ☐ Employed by other ☐

Business or Company Name:

Address:

City/State/Zip:

Patient Intake Information continues on next page.

Marital Status:

Please ☑ check one: Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widow ☐

Family:

Parents' Names & Ages:

Spouse's Name & Age:

Child's Name(s) & Ages:

Sibling Name(s) & Ages:

Present Concerns/Issues:

Briefly, please state the reasons for treatment (Use additional space as needed):

Medical Health:

Indicate your general medical health, please ☑ check one:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Present Medical Problems (if any):

Physician Care:

(If under physician's care please indicate the following:)

Physician's Name:

Address:

City/State/Zip:

Telephone:

Medication:

Please ☑ check all that applies: None ☐ Psychotropic ☐ Medical ☐ Other ☐

If you are taking medicine(s), please indicate the following:

Name Of Medication	Current Dosage / Frequency	Start date	Side Affects
			No ☐ Yes ☐
			No ☐ Yes ☐
			No ☐ Yes ☐
			No ☐ Yes ☐

Dr. Contact:

If you have previously been in psychotherapy, please state the therapist's name, address & telephone number and state reasons for treatment and dates.

Name of Psychotherapist:

Address:

Telephone:

City/State/Zip:

Reason:

Dates:

Patient Intake Information continues on next page.

Availability:

Please indicate the range of day and evening hours (starting times and leaving times) that you are available for session time Monday through Thursday. Appointments begin at 10:00am.

	Monday	Tuesday	Wednesday	Thursday
Daytime				
Evening				

Fee Rate / Session Time: (Please leave blank)

First Appointment Date: (Please leave blank)

Fee: 45 min. ☐; 60 min. ☐; 90 min. ☐; Other ☐.

Credit Card Information: (if applicable)

Please ☑ check one:

Visa ☐ MasterCard ☐ American Express ☐

Name on Card:

Credit Card Number:

Credit Card Expiration Date:

I authorize Dr. Marie Margenau-Spatz to charge my credit card account as payment for therapy session(s).

Print name as it appears on credit card:____

Signature:____

Please check ☑ "No" or "Yes" for questions 1 - 6 below:

1. Do you have a problem with drugs or alcohol? If yes, state the problem. No ☐ Yes ☐

2. Have you ever attempted suicide or homicide? If yes, give the details. No ☐ Yes ☐

3. Are you presently feeling suicidal or homicidal? If yes, describe your feelings. No ☐ Yes ☐

4. Have you ever been hospitalized for mental illness or drug abuse? If yes, state the problem , name and location of hospital and dates. No ☐ Yes ☐

5. Are you taking medication for psychological problems? If yes, list the medicine names and dosage. No ☐ Yes ☐

6. Do you have a history of mental illness or substance abuse? If yes, state the problem and dates. No ☐ Yes ☐

Patient Intake Information continues on next page.

Section II.

Please fill out this section. Your responses to the following questions will help me provide the most effective services to you. Thank you for your cooperation. Your answers to these questions are strictly confidential.

Assessment

Please assess how your current symptoms have affected the level of functioning in the following categories.

Please ☑ rate how much you were affected by the following in the week before your first therapy appointment.

	Not at all	Mildly	Moderately	Severely	Extremely
Concerns about your body or physical health	☐	☐	☐	☐	☐
Thoughts or behaviors you do over and over again	☐	☐	☐	☐	☐
Unusually high energy.	☐	☐	☐	☐	☐
Feeling sad, blue, or depressed.	☐	☐	☐	☐	☐
Anxiety, ‘nerves,’ or tension.	☐	☐	☐	☐	☐
Anger, hostility, or irritability.	☐	☐	☐	☐	☐
Fears of things or places.	☐	☐	☐	☐	☐
Beliefs that others want to hurt you.	☐	☐	☐	☐	☐
Drinking too much or using drugs.	☐	☐	☐	☐	☐
Unreal, strange, or bizarre thoughts.	☐	☐	☐	☐	☐

Please ☑check the box which best describes how well you are doing on your <u>job</u> or at <u>school</u>.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Working	Can not Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please ☑ check the box which best describes how well you are doing in your <u>marital / significant other</u> relationship.

0☐	1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Not Applicable	Can not Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Section II continues on next page.

Please ☑ check the box which best describes how well you are doing in your family relationships.

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Not Applicable	Can not Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please ☑ check the box which best describes how well you are doing in your social relationships.

0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Not Applicable	Can not Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please ☑ check the box which best describes your feelings about your financial situation.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor								Excellent

Please ☑ check the box which best describes your general happiness and well-being.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning relating to hobbies, interests, play activities.

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning in activities of daily living (i.e., personal hygiene, bathing, etc.)

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning re: physical health.

☐ Weight loss________lbs. ☐ Weight gain________lbs. Current weight________lbs. Height________

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐
Very Poor								Excellent

Section II continues on next page.

Please ☑ check the box which best describes your current functioning in <u>eating habits.</u>

☐ Weight loss________lbs. ☐ Weight gain________lbs. Current weight________lbs. Height________

1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning in <u>sleeping habits</u>.

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Early morning awakening

1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning in <u>sexual functioning</u>.

1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning in <u>ability to concentrate</u>.

1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor								Excellent

Please ☑ check the box which best describes your current functioning in <u>ability to control your temper</u>.

1☐	2☐	3☐	4☐	5☐	6☐	7☐	8☐	9☐
Very Poor								Excellent

Thank you for taking the time to complete this Intake Information Form.
The information you have given will be kept in the strictest confidence.

Dr. Marie Margenau-Spatz

End of Patient Intake. The following page is for administrative use only.

For Administrative Use Only.

Section III.

Functioning

Categories	Current Functioning									
Scale 0-9*	**#0 Not Applicable**	**#1 Can Not Function**	**#2**	**#3 Serious Problems**	**#4**	**#5 Moderate Functioning**	**#6**	**#7 Above Average Functioning**	**#8**	**#9 Excellent Functioning**
1. *Job or at School										
☐ Disability Leave ☐ Job Jeopardy										
Scale 0-9*	**#0 Not Applicable**	**#1 Can Not Function**	**#2**	**#3 Serious Problems**	**#4**	**#5 Moderate Functioning**	**#6**	**#7 Above Average Functioning**	**#8**	**#9 Excellent Functioning**
2. *Marital / Significant Other										
3. *Family Relationships										
4. *Social Relationships										
Scale 1-9		**#1 Very Poor**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**#8**	**#9 Excellent**
5. Financial Situation										
6. General Happiness / Well Being										
7. Hobbies / Interests / Play Activities										
8. Daily Living (i.e., personal hygiene, bathing, etc.)										
☐ Weight Loss__________lbs. ☐ Weight Gain__________lbs. ☐ Current Weight__________lbs. Height__________										
Scale 1-9		**#1 Very Poor**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**#8**	**#9 Excellent**
9. Physical Health										
10. Eating Habits										
11. Sleeping Habits										
☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Early Morning Awakening										
Scale 1-9		**#1 Very Poor**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**	**#8**	**#9 Excellent**
12. Sexual Functioning										
13. Ability to Concentrate										
14. Ability to Control Your Temper										

Risk Assessment (Check all that apply)

Suicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt Date __________

Homicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt Date __________

Other Risk Behaviors