Loudoun Psychological Services

In-Take Registration

SECTION 1: Demographic & Background Information:

Client's Name _____ Date _____

Telephone: Home _____ Work _____ Cell _____

If you do not want messages left on any of these telephone numbers, please circle the number.

Client's Email: _____

Address _____ City _____ State ___ Zip _____

Age _____ Date of Birth _____

Sex _____ Identified Gender _____ Marital Status _____

For Clients Under the Age of 18:

Father's Name _____ Cell _____ Email _____

Mother's Name _____ Cell _____ Email _____

Primary Care Physician: Name _____ Telephone _____

Household Members & Children – please list all members of your household and include all children.

Name	**Age**	**Relationship**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your reason for seeking therapy now? _____

_____

_____

_____

_____

_____

_____

Did anything or any life event trigger or cause this problem for you? ☐ Yes ☐ No

If yes, please describe what happened? _____

_____

_____

_____

Has anyone else been encouraging / pressuring / forcing you to seek help? ☐ Yes ☐ No

Have you participated in therapy before? ☐ Yes ☐ No

How many times? _____ What was the reason for seeking therapy in the past?

_____

_____

_____

Section 2: Partnership / Marital Relationship(s): **<u>Only complete this section if you are over 18</u>**

How many times have you lived with someone in a committed relationship or been married? _____

Are you currently: ☐ single ☐ dating casually ☐ dating one person ☐ married

☐ separated ☐ divorced ☐ living with a significant other _____

If married or living with a significant other, how long have you been together or married? _____

How well do you and your spouse / significant other get along?

☐ Very poorly ☐ Not too well ☐ Okay ☐ Pretty well ☐ Very well

Are you satisfied with your current spouse/partner? ☐ Yes ☐ No

Are you satisfied with your current relationship with your children? ☐ Yes ☐ No

What do you consider to be the purpose of marriage or your current relationship?

_____

_____

_____

_____

SECTION 3: Areas of Concern

Please check the symptoms below that are currently an issue **(C)** or have been an issue in the past **(P)**.

C ***P***	***C*** ***P***	***C*** ***P***	***C*** ***P***
☐ ☐ Addiction	☐ ☐ Disorientation	☐ ☐ Infidelity	☐ ☐ Phobia
☐ ☐ Aggression	☐ ☐ Disorganization	☐ ☐ Impulsivity	☐ ☐ Physical Illness
☐ ☐ Alcohol Use	☐ ☐ Domestic Violence	☐ ☐ Irritability	☐ ☐ Pleasure Loss
☐ ☐ Anger	☐ ☐ Drug Use	☐ ☐ Irresponsibility	☐ ☐ Pornography
☐ ☐ Anorexia	☐ ☐ Easily Distracted	☐ ☐ Jealousy	☐ ☐ Racing Thoughts
☐ ☐ Appetite Loss	☐ ☐ Fatigue	☐ ☐ Loneliness	☐ ☐ Recurring Thoughts
☐ ☐ Avoiding People	☐ ☐ Fear	☐ ☐ Loss of Control	☐ ☐ Restlessness
☐ ☐ Anxiety	☐ ☐ Gambling	☐ ☐ Low Energy	☐ ☐ Sleeping Problems
☐ ☐ Binge Eating	☐ ☐ Guilt	☐ ☐ Low Self Esteem	☐ ☐ Sexual Difficulties
☐ ☐ Chest Pain	☐ ☐ Hair Pulling	☐ ☐ Memory Loss	☐ ☐ Social Anxiety
☐ ☐ Confusion	☐ ☐ Hallucinations	☐ ☐ Mood Instability	☐ ☐ Stealing
☐ ☐ Compulsions	☐ ☐ Headaches	☐ ☐ Nightmares	☐ ☐ Suicidal Thoughts
☐ ☐ Crying	☐ ☐ Heart Racing	☐ ☐ Obsessions	☐ ☐ Trauma
☐ ☐ Depression	☐ ☐ Hoarding	☐ ☐ Overwhelmed	☐ ☐ Trembling/Shaking
☐ ☐ _____	☐ ☐ Hopelessness	☐ ☐ Panic Attacks	☐ ☐ Worry
☐ ☐ _____	☐ ☐ Indecision	☐ ☐ Perfectionism	☐ ☐ Worthless Feeling

Additional information:

_____

_____

_____

_____

_____

_____

SECTION 4: Family History

Have any other members of your family experienced a psychiatric / emotional disorder? ☐ Yes ☐ No

If yes, please provide as much information as you know about the nature of the disorder, treatment and current status: _____

_____

_____

_____

Regarding your mother: Current age _____ If deceased, how long ago did she die? _____

Occupation: _____ If retired, her previous occupation: _____

Regarding your father: Current age _____ If deceased, how long ago did he die? _____

Occupation: _____ If retired, his previous occupation: _____

How well did your parents get along with each other?

☐ Very poorly ☐ Not too well ☐ Okay ☐ Pretty well ☐ Very well

Are your parents separated or divorced? ☐ Yes ☐ No

If divorced, has your **mother** remarried? ☐ Yes ☐ No

If divorced, has your **father** remarried? ☐ Yes ☐ No

Were you adopted or raised by parents other than your biological parents? ☐ Yes ☐ No

Did anything unusual happen to you while you were growing up? ☐ Yes ☐ No

Which members of your family are you close to and why? _____

_____

_____

Which members of your family were a source of hurt or pain to you and why? _____

_____

_____

SECTION 5: Medical History

Medication Name	Dosage	Purpose

When was your most recent physical exam? _____

Were any medical issues identified or discussed?

_____

_____

_____

_____

List any major illnesses, injuries, and/or operations you have had:

_____

_____

_____

_____

Do you smoke? ☐ Yes ☐ No

Do you exercise on a regular basis? ☐ Yes ☐ No

On average, how many hours of sleep do you get per night? _____

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you have trouble staying asleep? ☐ Yes ☐ No

Do you wake up too early in the morning? ☐ Yes ☐ No

Do you sleep *too much* or *not enough*? ☐ Yes ☐ No

Have you gained or lost weight recently? ☐ Yes ☐ No

Was the weight loss / gain intentional? ☐ Yes ☐ No

Do you eat a well-balanced nutritional diet? ☐ Yes ☐ No

Do you eat *too much* or *not enough*? ☐ Yes ☐ No

SECTION 6: Substance Use:

Do you drink alcoholic beverages on a regular basis? ☐ Yes ☐ No

If yes, what is your preferred beverage(s)? _____

How many drinks do you have per day _____ or per week _____ or per month? _____

Are you concerned about the way you drink alcohol? ☐ Yes ☐ No

Is anyone close to you concerned about the way you drink alcohol? ☐ Yes ☐ No

If yes, what relationship does this person(s) have to you? _____

Do you use any recreational drug(s) besides alcohol on a regular basis? ☐ Yes ☐ No

If yes, what recreational drug(s) do you take? _____

How often do you use recreational drugs? _____

Are you concerned about your use of recreational drugs? ☐ Yes ☐ No

Is anyone close to you concerned about your use of recreational drugs? ☐ Yes ☐ No

If yes, what relationship does this person(s) have to you? _____

Does anyone in your family have a history of alcohol/drug abuse/dependence? ☐ Yes ☐ No

If yes, what relationship does this person(s) have to you? _____

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many packs do you smoke per day? _____

Do you drink caffeinated beverages? ☐ Yes ☐ No

If yes, what caffeinated beverages do you drink? _____

How many 12 ounce caffeinated beverages do you drink daily? _____

SECTION 7: Friendships:

On a scale of 1 – 10, with 10 being very out-going (extroverted) and 1 being very shy (introverted), where would you put yourself? Please circle the one that most closely fits -

1	2	3	4	5	6	7	8	9	10

Do you have close friends? ☐ Yes ☐ No

Do your friends live close by, and do you see them on a regular basis? ☐ Yes ☐ No

Are you satisfied with your current friendship status? ☐ Yes ☐ No

Overall, how well do you get along with people outside your family? (Please check the answer below).

☐ Very poorly

☐ Not too well

☐ Okay

☐ Pretty well

☐ Very well

SECTION 8: Education:

Are you currently in school? ☐ Yes ☐ No

If yes, what school are you attending? _____

What are you studying? _____

How many courses are you taking per quarter or semester? _____

What is your highest educational degree?

☐ High School ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

What is/was the name of the last college you attended? _____

What was your major? _____

How well did you do or are doing in school?

☐ Not so well ☐ Okay ☐ Good ☐ Excellent

Are you satisfied with your educational achievement? ☐ Yes ☐ No

SECTION 9: Employment

Where do you work? _____

What kind of work do you do? _____

What is the purpose of work? _____

How well do you function at work?

☐ Very poorly ☐ Not so well ☐ Okay ☐ Good ☐ Excellent

Are you satisfied with your current employment status? ☐ Yes ☐ No

SECTION 10: Spirituality

How important is spirituality / religion to you? _____

What religion were you raised in? _____

Are you currently a member of a religion? ☐ Yes ☐ No If yes, which one? _____

Are you satisfied with your current spiritual / religious practice? ☐ Yes ☐ No

SECTION 11: Self Care

How important to you is time to yourself? _____

Do you get enough time daily to take care of yourself? ☐ Yes ☐ No

What kind of leisure activities / hobbies do you enjoy? _____

_____

How well are you managing your finances?

☐ Very poorly ☐ Not so well ☐ Okay ☐ Good ☐ Excellent

How well are you handling routine chores (e.g. laundry, cleaning, cooking)?

☐ Very poorly ☐ Not so well ☐ Okay ☐ Good ☐ Excellent

Are you satisfied with your self-care status?

☐ Yes ☐ No

SECTION 12: Insurance Information

Name of Insurance Company _____ Policy Number _____

Primary Insured's Name _____ Group Number _____

Please read the following statements, check yes or no, and sign and date below:

☐ Yes	I understand that I am responsible for all charges for services provided me regardless of insurance reimbursement.
☐ Yes	I agree to pay all fees owed by me at the time of my visit.
☐ Yes	I agree to pay the full fee for appointments not cancelled 24 hours in advance.
☐ Yes	I give Loudoun Psychological Services, LLC permission to release information obtained from me that is necessary to authorize treatment and obtain reimbursement from my insurance plan.
☐ Yes	I assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Loudoun Psychological Services, LLC.

Client's Signature: _____ Date: _____