Alinda Small
Suite 303
185 Elizabeth Street
Sydney 2000
AVS2016@outlook.com
041-492-4921

Intake Form

Date of first appointment:

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by:
□ Medical Provider:
_____
_____
□ Website at http://www.alindasmall.com
□ Psychology Today website
□ Friend/Family:
_____

Have you previously received any type of mental health services? □ No □ Yes

If yes, which of the following:

□ psychotherapy □ medication □ outpatient hospitalizations □ inpatient hospitalization

Briefly, what brings you in today?

When did your problem first start? Within the last:
□ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

What areas of your life have been affected because of this problem?

What would you like to accomplish out of your time in therapy?

Family History

Where were you born?

_____

Where did you grow up?

_____

□ city □ suburbs □ country

Who did you live with, growing up?

_____

Mother's occupation:

_____

Father's occupation:

_____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no : which was---	

Marital Status:
□ Never Married
□ Domestic Partner □ Married

For how long?_____

Please give partners name: _____

On a scale of 1-10 (best), how would you rate your relationship? _____

□ Separated □ Divorced □ Widowed

If widowed, please give partners name, and year deceased:
_____

Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

Please list any children, their names, and ages:

Name	Age	Name of other parent	If deceased, age and cause of death

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Began/Stopped

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

If you are having problems, in which phase of sleep? (please circle)

Falling asleep: staying asleep awakening early sleep apnea

Please list any other specific sleep problems you are currently experiencing: