Jasmine Teleki, PsyD
Clinical Psychologist CA Lic# 23733

257 Castro Street, #218
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(650)906-9571
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Patient Intake Form

Patient Information

First Name: _____

Last Name: _____

Address: _____

_____

City: _____

State: _____ Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Date of Birth: ____ / ____ / ____

Gender: _____M _____F

Preferred Email Address: _____

Emergency Contact

First Name: _____

Last Name: _____

Address: _____

_____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Relationship to you: _____

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Your Problems and Goals

Briefly list the three main problems that have led you to seek help.

	The Problems	How long has this been bothering you?
1		
2		
3		

Briefly describe your specific therapy goals. What would you like to gain from this experience?

	Goals
1	
2	
3	

This is how my life would be different if I was able to effectively address the problems above:

_____

_____

_____

Things I have done in the past to help deal with these issues:

_____

_____

_____

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On the list below, circle any problems or concerns you currently have.

Adjustment to a new situation
Career/job concerns
Academic problems
Financial problems
Spiritual or religious concerns
Legal problems
Family problems
Relationship problems
Learning disability
Attention or concentration difficulty
Try to do too much
Racing thoughts
Periods of getting too excited or hyper
Anxiety
Intense fears
Panic attacks
Chronic muscle tension
Procrastination
Perfectionism
Shyness
Afraid to leave home
Feelings of detachment
Stress
Tics, repetitive body movements
Hair pulling or skin picking
Hoarding, keeping too many things
Trauma
Upsetting memories
Nightmares
Depression
Sadness
Guilt
Feeling doomed or hopeless
Thoughts of suicide or death
Can't make decisions
Not interested in things like before
Concentration problems
Fatigue, feeling tired all the time
Insomnia
Sleeping too much
Loss or grief
Loneliness
Self-esteem
Irritability
Significant weight loss or gain
Medical or health concerns
Fertility concerns
Addiction
Hard to control urges
Doing risky things
Mood swings
Cutting or self-injury
Identity or sense of self
Hard to control my anger
Too concerned about others
Assertiveness
Communication skills
Problems in social situations
Paranoia
Thoughts that don't make sense to me
Disorganization
Eating concerns
Body image
Purging food
Abuse, harassment
Sexual problems
Sexuality concerns
Gender concerns
Hard to know how I feel
Social skills

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You and Your Family Background

How do you describe your ethnic background? _____

Were you raised with a spiritual or religious affiliation?_____

If so, what was it? _____

Are you currently active in your religion? _____

Where did you grow up? _____

How many times did you move before you were 18? _____

Did you feel like you fit into the community in which you were raised?_____

Briefly describe the relationship between your parents.

_____

_____

_____

Briefly describe your father, his personality, and what your relationship is or was like with him.

_____

_____

_____

Briefly describe your mother, her personality, and what your relationship is or was like with her.

_____

_____

_____

If there were/are problems in your relationship with one or both of your parents, please mention the most important one(s).

_____

_____

_____

How much does this bother you now?

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___Not at all ___A little ___Moderately ___Very much ___Couldn't be worse

Please provide the names and details about your siblings below. Include any step- or half-siblings or any other children raised by your parents.

First name	Occupation	Age	Sex	Comments

Describe any important relationships with your siblings, whether helpful or problematic for you.

_____

_____

_____

What was the general atmosphere like at home?

_____

_____

_____

Were there any important changes, like moves or other significant events, during your childhood or adolescence?

_____

_____

_____

Was there someone else who was important to you during your childhood (e.g., grandparents, aunts/uncles, family friends, etc.)? If so, say a few words about them.

_____

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_____

_____

Were you adopted? _____

Does anyone in your family have a history of (check yes, no, or not sure)?

Yes	No	Not sure	
			Attention problems/ADHD/ADD
			Addiction issues
			Depression
			Anxiety, fears, phobias
			Bipolar disorder, manic depression
			Schizophrenia
			Eating disorders

You Education

Describe your education, where you went to school, how much schooling you've had, and how you performed academically.

_____

_____

_____

Were you ever diagnosed with or suspect you had a learning disability?

_____

Did you enjoy school?

_____

_____

_____

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What job or main role do you currently do?

_____

_____

_____

Say something about your past working life.

_____

_____

_____

Are you satisfied in your current role?

_____

_____

_____

Have you ever been fired from a job?_____

Relationship History

Describe any previous important relationships. Include how long they lasted and why you think the relationship(s) ended.

_____

_____

_____

_____

_____

_____

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Do you have a romantic partner now? _____

If yes, say something about the history of the relationship, your level of satisfaction with it, and any particular problems that are currently on your mind.

_____

_____

_____

If you have children, please list them in birth order.

_____

_____

_____

If applicable, describe your relationship with your children. If there are difficulties, list the most important ones here.

_____

_____

_____

You Psychiatric and Medical History

Do you have any psychiatric or emotional diagnoses for which you have been treated in the past?

_____

_____

Have you ever been hospitalized for any emotional or psychiatric reason?

_____

Have you been prescribed any psychiatric medications? If so, please describe.

_____

Do you have any history of making suicide attempts or physically harming yourself? If so, please say a few things about that here.

_____

_____

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How is your physical health at present? _____

What are your major health concerns? _____

The date of your last physical exam? _____

Have you been hospitalized for any medical conditions in the past year? _____

Are you taking any non-psychiatric medications or over-the-counter drugs or herbal supplements? If yes, please describe.

_____

_____

_____

Do you follow any special diets?

_____

Alcohol and Drug Use

1. How many alcoholic drinks do you have in a typical month?_____

2. Has anyone ever been annoyed with your alcohol or drug use? _____

4. Have you ever been hooked on a prescription medication or taken a lot more of it than you were supposed to? _____

5. Do you use any street drugs medicinally or recreationally? _____

How much caffeine do you drink daily? _____

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Please mention any particular satisfaction that you draw from your family life, your work life, or any other areas that are important to you.

_____

_____

_____

Could you tell me something about your plans, hopes, and expectations for the future?

_____

_____

_____

What would you say are your strengths and most positive qualities?

_____

_____

_____

Please let me know how you felt completing this questionnaire?

_____

_____

_____

Is there anything else you'd like me to know?

_____

_____

_____