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CLINICAL PSYCHOLOGIST/ MARRIAGE & FAMILY THERAPIST/ CONSULTANT
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Welcome! I am delighted to have the opportunity to serve you. Your cooperation in completing this intake will be helpful in customizing treatment for you. If any question is objectionable, or you have questions, please feel free to discuss this or any other concern with me. Thank you.

PERSONAL INFORMATION

Today's Date _____ Referred By _____

Please provide the following information:

This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in my consent to treatment.

Name _____ Male ____ Female _____

Address _____ City _____ Zip Code _____

Phone numbers: Home () _____ Cell () _____

Work () _____ Other _____

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, text, or other means. Your confidentiality is important, therefore please indicate your preference by checking the appropriate choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

____ You may call me at my home. My home phone number is: () _____

____ You may call or text on my cell phone. My cell phone number is: () _____

____ You may call me at work. My work phone number is: () _____

____ You may send mail to me at my home address.

____ You may send mail to me at my work address.

____ You may communicate by email. My email address is: _____

____ You may send a fax to me. My fax number is: () _____

Personal Information

Age _____ Birthdate _____

E-mail address _____

Occupation _____ Employer _____

Work Address _____ City _____ Zip Code _____

Previous Occupation _____ Education: _____

Model, year and color of car you drive _____

Marital Status: _____

Religious affiliation: Childhood _____ Present: _____

Would you like spirituality/religious issues to be a part of your therapy? Y___ N___

When were you last examined by a physician?

List any health problems for which you are being treated

Primary Care Physician:

name _____ Phone _____

May I coordinate your treatment with your physician? Yes _____ No _____

EMERGENCY CONTACT:

Name: _____ Phone: _____

Why are you seeking therapy? (What would you like to accomplish.)

How would you rate how serious this issue feels to you? (Circle one)

1 2 3 4 5 6 7

Mildly upsetting

Extremely Serious

GENERAL CONSENT TO THERAPY

I apply for and consent to psychotherapy and diagnostic testing as prescribed by the therapist. I agree to be responsible for the payment of \$200.00 per 45 minute session, payable at each session. (You may also choose options of 90, 60, or 25 minute sessions, prorated, to best serve your needs.) The initial diagnostic session is \$250. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company. I also understand that my appointment not kept or not cancelled 24 hours in advance will be charged to me.

Signature _____

Family Information:

Present marital status: Single____Married ____Divorced ____Separated ____Widower ____

Significant Other _____

If married: Name of Spouse _____ Age of Spouse _____ Date of Marriage_____

Would you describe your intimate relations as satisfactory or unsatisfactory? _____

If separated: Date of Separation:_____

If divorced: Date of marriage to ex-spouse _____

Date of Divorce _____

If divorced more than once: Date of previous marriage____

Date of previous divorce _____

If you have a "Significant Other": Name _____

How long known _____ Living together? _____

Children: Names and Ages of Children _____

Other children living with you: Names, ages, and their relationship to you _____

FAMILY HISTORY

Father: Age _____ Occupation _____ Living? Y/N;

Mother: Age _____ Occupation _____ Living? Y/N,

Did you grow up with both parents in the home? Y/N

Step-father: Name _____ Age _____

Step-mother: Name _____ Age _____.

Who you feel closest to? Your Father ___ Mother ___ Neither ___ Other (please specify) _____

Briefly describe your relationship with your Father _____

With your mother _____

Brothers' names and ages _____

Sisters' names and ages _____

Briefly describe your relationship with your siblings _____

Has any member of your family ever suffered from anything that could be described as an “emotional” or “psychological” problem? _____

Please mention any history of domestic violence, child abuse or sexual abuse in your family:

Please comment on any history of alcohol or drug use in your family:

MEDICAL HISTORY:

Please place a number beside each illness or condition to indicate the frequency or severity:

1-Never, 2 - Seldom, 3-Sometimes, 4-Often.

Please include any further information you feel is relevant on each condition.

Loss of Appetite

Constipation

High blood Pressure

Allergy

Fatigue

Anemia

Nausea

Arthritis

Diarrhea

Chronic Pain

Headaches

Diabetes

Asthma

Vision / Hearing impaired

High Cholesterol

Epileptic seizures

Others (please indicate) _____

EMOTIONAL CONCERNS: 1-Never, 2 - Seldom, 3-Sometimes, 4-Often.

Please include any further information you feel is relevant

Insomnia

Loss of temper

Depression

Mood Swings

Tearfulness

Shyness

Panic Attacks

Phobias

Hopelessness

Inferiority

Insecurity

Stress

Nervousness

Loneliness

Anxiety

Self-control

Tiredness

Actions or rituals you can't stop

Fearfulness

Confusion

Difficulty letting go of thoughts

Alienation

Please write any other emotional concerns:

Do you smoke? Y/N Amount _____ Do you drink alcohol? Y/N

How much per week? _____

Are you currently using illegal drugs? Y/N which ones? _____ Have you in the past? _____

Current Weight _____ One Year Ago _____ Maximum _____ When? _____

Do you exercise regularly? Y/N How? _____

Do you sleep well? Y/N Amount (hours/night) _____ Easy to get to sleep? Y/N

Other info: _____

What was the hardest time in your development ___Preschool ___Grade School ___Jr. High
___High School ___College ___Now

Why?

TREATMENT AND MEDICATION HISTORY

Please indicate by putting a number next to the medication how often you use any of the following:

(1-Never, 2-Occasionally, 3-Frequently, 4-Daily)

____Appetite suppressants

____Aspirin

____Sedatives/Tranquilizers

____Sleeping Pills

____ Stimulants

____ Blood Pressure Medication

____ Heart Medicine

____ Vitamins

____ Please list all others _____

Please list all current prescription medications: names, dosages (These must be kept in your confidential file by law) Please keep me informed of any prescription changes.

Medication name

Dosage

Date began

| | | |
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Have you ever had any previous counseling or psychotherapy? Y/N

If yes, when? _____ Length of time _____

Where _____

What were the issues you worked on?

Name of therapist(s)

Was therapy successful? Y/N

Have you ever been hospitalized for psychiatric reasons? Y/N If yes, when and where?

Length of hospital stay:

Please state any support Groups, Twelve- Step program involvement, church or other forms of support_____

PRIMARY GOALS

What would you say are your top three **primary goals** for your therapy?

What do you consider your strengths and weaknesses in meeting your goals?

Is there anything you would like to tell me about yourself that is not on this form? Feel free to write on the back or use additional paper if needed.

Thank you for completing this questionnaire.

Please feel free to discuss any portion of it with me that is of particular interest or concern to you.