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INTAKE INFORMATION

I'd like to get some background information from you before we begin working together. The form typically takes no more than 15 minutes to complete. Your completion of it should help me understand your situation more quickly.

I appreciate you taking the time to provide this information.

Current Date: ___ / ___ / ___

Name: _____

Date of Birth: ___ / ___ / ___

Current Address: _____

City _____ State _____ Zip _____

Permanent Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

May I contact you at home? No Yes On your cell phone? No Yes

May I leave a message on your cell phone? No Yes

May I leave a message for you at your home? No Yes

May I contact you by email? No Yes

If yes, what is your email address? _____

What is the *best* way to reach you? _____

In case of an emergency please notify: _____

Emergency Phone Number(s): _____

Relationship: _____

Do I have permission to contact this person in case of emergency? No Yes

If contacted, information will be carefully disclosed.

Demographic Information

Gender:

Male Female Transgender GenderQueer Other_____

What race or culture do you consider yourself? (Please list all that apply.)

Sexual Orientation:

Heterosexual Gay/Lesbian Bisexual Fluid Queer
 Questioning Other: _____

Relationship Status:

Single Engaged Married Partnered Separated
 Divorced Remarried Widow/Widower

Is your spouse/partner basically supportive of your seeking counseling?

No Yes N/A

Number of children: _____

Children's Names & Ages:

Academic Status (if you are a student):

Academic Institution, Year:

Current GPA: _____

Referred by:

Self Family Professor/Adviser Friend Counselor/Psychologist
 Other:_____

If you were referred by a fellow professional (doctor, therapist, etc), may I contact this person to thank them for the referral (without disclosing any information about you?) No Yes

Treatment Information

Have you had previous counseling? No Yes
If yes, when?

With whom?

For what issue?

With what general results?

Do you take any medication for mental health reasons? No Yes
If yes, which ones, what dosage, and for how long?

Have you ever been hospitalized for a psychiatric reason? No Yes
When and for what reasons?

Have you ever had substance abuse treatment? No Yes
When and for what?

Do you participate in any support groups? No Yes
If yes, which?

Please check if you have experienced any of the following types of trauma or loss:

- | | | |
|--|--|---|
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Neglect |
| <input type="checkbox"/> Crime victim | <input type="checkbox"/> Multiple family moves | <input type="checkbox"/> Placed a child for adoption |
| <input type="checkbox"/> Teen pregnancy | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Parent/Guardian illness (during childhood) |
| <input type="checkbox"/> Homelessness | <input type="checkbox"/> Violence in the home | |
| <input type="checkbox"/> Lived in a foster home | <input type="checkbox"/> Parent/Guardian substance abuse | |
| <input type="checkbox"/> Other (please specify): | | |

Medical Information

When was your last physical? _____

Have you ever experienced any of the following medical conditions?

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Frequent upset stomach | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Diabetes | <input type="checkbox"/> STD |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Abortion | |
| <input type="checkbox"/> Other (please specify): | | |

Please list any CURRENT health concerns:

Please check all of the behaviors and symptoms that are concerns for you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety Issues | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Parenting problems |
| <input type="checkbox"/> Frequent worry | <input type="checkbox"/> Withdrawal from people | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Self-harm behaviors | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Social discomfort | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Social isolation | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Fear away from home | <input type="checkbox"/> Thoughts of death/suicide | <input type="checkbox"/> Problems with pornography |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Attention Issues: | <input type="checkbox"/> Gambling problems |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Computer addiction |
| <input type="checkbox"/> Suspicion/paranoia | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Alcohol/drug use | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Visual hallucinations |
| | <input type="checkbox"/> Easily confused | |
| | <input type="checkbox"/> Poor memory | |
| <input type="checkbox"/> Mood Issues: | <input type="checkbox"/> Racing thoughts | |
| <input type="checkbox"/> Crying spells | | <input type="checkbox"/> Acculturation/Cultural Adjustment |
| <input type="checkbox"/> Sadness/depression | <input type="checkbox"/> Anger Issues | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Spiritual/Religious Matters |
| <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Irritability/anger | |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Homicidal thoughts | |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Peer conflict | |
| <input type="checkbox"/> Inability to enjoy | <input type="checkbox"/> Property destruction | <input type="checkbox"/> Death of a Loved One |
| <input type="checkbox"/> Low self worth | | |
| <input type="checkbox"/> Shame | | |
| <input type="checkbox"/> Mood swings | | |
| <input type="checkbox"/> Specific Phobias (please specify): | | |
| <input type="checkbox"/> Other: | | |

Please state the reason(s) and concern(s) for which you are seeking counseling and any other helpful information:

How long have these concern(s) been bothering you?

Have you ever in your lifetime had thoughts of harming yourself? No Yes
If yes, when was the most recent time?

Have you purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, hair pulling, etc.)?
 No In the past, but stopped Yes, currently

In the last week, have you had suicidal thoughts (i.e., thoughts of killing yourself)? No Yes

If yes, what is the frequency? Rarely Sometimes Frequently Always

What is the duration? Seconds Minutes Hours Constant

What is the intensity?

Brief and fleeting Focused deliberation Intense rumination

Have you seriously considered attempting suicide in the past? No Yes

Have you ever attempted to commit suicide? No Yes
If yes, when?

Did you receive help? No Yes
Where/from whom?

Have you seriously considered harming another person? No Yes
If yes, whom? When?

Have you intentionally physically harmed someone? No Yes
If yes, when?

Have you ever been physically hurt/threatened by someone? No Yes
If yes, when?

What have you found helpful to cope during difficult times?

Family Information

One or both parents deceased (Please specify):

Parents married/partnered & living together

Parents divorced or separated

Your age at parents' separation: _____

Mother remarried - number of times: _____

Father remarried - number of times: _____

Your siblings and their ages:

Have any of your family members experienced any of the following (please indicate who):

Attention/Hyperactivity Problems

Suicide Attempts

Anxiety

Eating Disorder

Panic Attacks

Sexual Abuse Survivor

Obsessive/Compulsive Behavior

Alcohol Abuse

Depression

Drug Abuse

Manic Depression (Bipolar)

Schizophrenia

Abusive Behavior

Anger Management Problems

Substance Use

How often do you drink caffeine?

Do you regularly use alcohol? No Yes

In a typical month, how often do you have 4 or more drinks in a 24-hour period?
 Never Rarely Monthly Weekly Daily or Almost Daily

Do you consider your alcohol consumption a problem? No Yes

Have you used any drug in the past 30 days that was not prescribed by a doctor (for example, marijuana, meth, cocaine, diet pills, ecstasy, Xanax, Ritalin, Adderall, LSD, acid, mushrooms, heroin, codeine, or other?) No Yes

How often do you engage in recreational drug use?
 Never Rarely Monthly Weekly Daily or Almost Daily

Has anyone ever expressed concern about your drinking or drug use?
 No Yes

Have you ever tried to stop your drinking or drug use, but could not?
 No Yes

Miscellaneous Information

Are you currently employed? No Yes

If yes:

Employer: _____

Position: _____

Length of time in this position: _____

Stress level of this position: Low Medium High

Have you been/are you now in the military? No Yes

If yes, were you in combat? No Yes

When/where? _____

Have you ever been convicted of a felony? No Yes

If yes, what/when? _____

Are you currently involved in any divorce or child custody proceedings?

No Yes

If yes, please explain:

Are you involved in any type of spiritual practice? No Yes

If yes, please briefly describe:

Do you have a local support network (friends, family, church, etc)? No Yes

If yes, please briefly describe:

****Please answer the following 5 questions based on how you've felt in general over the past week****

1) I feel sad, blue, or down....

I do not feel sad, down, or blue.

rarely.

sometimes.

often (more times than not).

2) My appetite...

My appetite is normal and hasn't changed.

is somewhat lower OR higher than normal.

is significantly lower OR higher than normal.

has changed so much that I do not want to eat at all

I want to eat all the time.

3) My energy level...

My energy level is normal.

is noticeably lower than normal.

is much lower than normal.

is so low that I can hardly conduct my daily activities.

- 4) I have lost interest and pleasure in things that I usually enjoy...
- I have interest in things I usually enjoy & get as much pleasure from them as I always have.
 - I have lost some of my interest in things, but still enjoy activities & get pleasure from some activities.
 - I have lost interest and pleasure in most things.
 - I have lost interest and pleasure in all things.
- 5) I feel guilty and down on myself...
- I do not feel guilty or down on myself.
 - sometimes.
 - much of the time.
 - all of the time.

Relationships

Please rate on the scale of 1 to 5, with 1 being low and 5 being high:

The general relationship you had/have with your father(s): _____

The general relationship you had/have with your mother(s): _____

The general relationship you had/have with your siblings (could vary with each sibling; if so, indicate "varies"): _____

If you are in an intimate relationship, rate it in general terms: _____

Your feelings regarding your current social network: _____

If you have a job, rate your relationship with your work colleagues: _____

If you have children, rate your relationship with them (could vary with each child; if so, indicate "varies"): _____

School Functioning (Parent/guardian complete for CHILDREN ONLY)

Child's year (ex., 5th grade): _____

Child's academic performance (As, Bs, etc): _____

Has there been a drop in grades recently? No Yes

Please describe child's behavior and/or attendance problems, if any:

Has there been an increase in behavior problems at school recently? No Yes

Is there any special education plan in place? No Yes

If yes, please describe:

**If there is any other information that you would like to provide,
please feel free to include it here:**

Thank you for taking the time to complete this confidential information form.