Holly H. Shah, Psy.D.
51 E. Campbell Ave., Ste. 110-C, Campbell, CA 95008
PH: 408-376-4540 FAX: 408-376-4541 Email: drhollyshah@gmail.com

CLIENT INTAKE FORM

Please answer the following questions to the best of your ability. These questions are intended to help the therapist with the therapy process. All information is completely confidential.

PERSONAL INFORMATION

Name: _____
(Last) (First) (Middle Initial)

Name of Parent/Guardian (if minor): _____
(Last) (First) (MI)

Birth Date: _____/_____/_____ Age: _____ Gender: ____Male ____Female ____Transgender

Marital Status: ____Never Married/Single _____Partnered _____Married ____Divorced _____Widowed

Number of Children: _____ Ages: _____

Current Address: _____

_____

Home Phone: _____ May I leave a message? Yes No

Cell/Other: _____ May I leave a message or text? Yes No

Email: _____ May I email you? Yes No

*Note: Emails may not be confidential

Referred by: _____

Are you currently receiving psychological services, counseling, psychiatric services, or any other mental health services? Yes No If yes, please describe: _____

_____

Have you had any mental health services in the past? Yes No

If yes, describe: _____

_____

Are you currently taking any psychotropic medication? Yes No If yes, please list below:

_____

_____

If no, have you ever taken psychotropic medication in the past? Yes No If yes, please list below:

_____

GENRAL HEALTH AND MENTAL HEALTH INFORMATION

How is your physical health at the present time?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any persistent physical symptoms or health concerns (ie. Chronic pain, headaches, constipation, hypertension, diabetes, thyroid dysfunction, etc.): _____

_____

Are you currently taking medication for your physical/medical issues? Yes No If yes, please list:

_____

_____

Are you having any problems with your sleep habits? Yes No If yes, please circle which applies:

Sleep too much Difficulty falling asleep Poor Sleep Quality Disturbing Dreams

Other: _____

How many times per week do you exercise? _____days _____minutes
What type of exercise do you engage in? _____

Are there any changes or difficulties with your eating habits? Yes No If yes, please circle which applies: Loss of appetite Increased appetite Binging Restrictive diet Poor Nutrition

Have you experienced a weight change in the past two months? Yes, how much: _____ No

Do you consume alcohol regularly? Yes No
In one month, how many times do you consume more than 3 drinks in one 24-hour period of time? _____

Do you use medicinal marijuana? Yes No If yes, for what condition? _____

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

Have you felt depressed recently? Yes No If yes, for how long? _____

Have you had any suicidal thoughts recently or ever in the past? Yes No
If so, how recent and how frequent? _____

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship? _____
On a scale from 1-10, how would you rate the quality of your relationship (10 being great): _____

In the last year, have you had any major life changes (ie. New job, moved, illness, relationship changes, births, deaths):_____

SYMPTOMS

Circle the symptoms you've experienced:		Trauma	Sexual problems
Extreme depressed mood	Mood swings	Rapid Speech	Extreme anxiety
Repetitive thoughts	Phobias	Disturbed sleep	Hallucinations
Memory lapse	Panic attacks	Body complaints	Time loss
Homicidal thoughts	Repetitive behavior	Trouble planning	Relationship problems
Alcohol/Substance abuse	Suicide attempts	Anxiety	Difficulty focusing/concentrating

OCCUPATIONAL / EDUCATIONAL INFORMATION

Are you currently employed? Yes No
If yes, who is your employer? _____ Position: _____
Do you feel happy and fulfilled by your work? Yes No
Does your work make you feel stressed? Yes No
What are your work related stressors? _____

What is your highest level of education completed to date?
High School/GED Some College 2-year College Bachelor's Master's Doctorate
Are you currently a student? Yes No
If yes, what are you studying? _____

RELIGIOUS/SPIRITUAL INFORMATION

Do you practice a religion? Yes No If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? Yes No

FAMILY MENTAL HEALTH INFORMATION

The following is to provide information about your family history. Please mark each as a "yes" or "no." If yes, please indicate the family member(s) affected.

Issue			*Family Member(s)*
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive	Yes	No	_____
Schizophrenia	Yes	No	_____

OTHER INFORMATION

List your strengths: _____

_____

List areas you believe you need to develop: _____

_____

What do you like most about yourself? _____

_____

What are some ways you cope with obstacles and stress? _____

_____

What are your goals for therapy? What would you like to accomplish?

_____

_____

_____

Additional information you'd like to add:

_____

_____

_____