Dr. Jorge J. Asturias, PsyD, Inc.
A Professional Psychology Corporation

INTAKE FORM

PLEASE PROVIDE THE FOLLOWING INFORMATION AND ANSWER QUESTIONS BELOW.
NOTE: THE INFORMATION YOU PROVIDE HEREIN IS PROTECTED AS CONFIDENTIAL INFORMATION.

Patient Name:_____
Last First

Parent/Guardian Name (Patient is under 18 years old)

_____
Last First

Date of Birth:_____ **Age:**_____ **Gender: Male____Female____**

Marital Status: Never Married_____ Domestic Partner_____ Married_____
Separated_____ Divorced_____ Widowed_____

Children and Ages in the Family:_____

Home Address:_____

_____California_____

Home Phone Number:_____ Confidential: Yes_____ No_____

Mobile Phone Number:_____ Confidential: Yes_____ No_____

Work Phone Number:_____ Confidential: Yes_____ No_____

Email Address:_____@_____.com
Please note E-mail correspondence is not considered confidential or private and is used only for administrative purposes.

I agree to having email correspondence: Yes_____ No_____ Initials_____

Referred By:_____

MENTAL HEALTH TREATMENT HISTORY

1. Have you previously received any type of mental healthcare services (e.g., psychotherapy, psychiatric, substance abuse treatment)?

No _____ Yes _____
Name, Title, and Telephone of Provider:_____

2. Are you currently taking any prescription medication for any medical condition?

No _____ Yes _____
Name and dose(s) of Medication(s)_____
_____

3. Have you or are you currently taking any psychiatric medication(s)?

No _____ Yes _____
Name and dose(s) of Medication(s)_____
_____

4. Are you currently or in the recent past experienced overwhelming sadness, grief, or depression?

No _____ Yes _____
Describe and provide Date of Onset:_____
_____

5. Are you currently or in the recent past experienced chronic anxiety, panic attacks, or phobias?

No _____ Yes _____
Describe and provide Date of Onset:_____
_____

6. Do you have a history of childhood, adolescent, or adult trauma (e.g., sexual, physical, psychological, emotional)?

No _____ Yes _____

7. How often do you drink alcoholic drinks?

Daily_____ A few times a Week _____ Once a Week_____ A few times a Month_____
Once a Month_____ Rarely_____ Never_____ Socially_____(only during social events)

8. Do you have a current or past history of drug (illegal or prescribed) use or treatment?

No _____ Yes _____
Describe and provide last Date of Use:_____
_____

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FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of mental health disorders and/or treatment and indicate which family member (father, mother, brother, sister, etc.) it applies to.

Condition	Yes/No	Family Member	Maternal/Paternal
1. Alcoholism/Drug Use	Yes / No	_____	M/P
2. Anxiety	Yes / No	_____	M/P
3. Depression	Yes / No	_____	M/P
4. Domestic Violence	Yes / No	_____	M/P
5. Eating Disorders	Yes / No	_____	M/P
6. Obsessive Compulsive Disorder (OCD)	Yes / No	_____	M/P
7. Schizophrenia	Yes / No	_____	M/P
8. Suicide Attempts or Ideation	Yes / No	_____	M/P
9. Psychiatric Care or Hospitalizations	Yes / No	_____	M/P
10. Imprisonment	Yes / No	_____	M/P
11. Other		_____	M/P

GENERAL HEALTH QUESTIONS

1. How do you rate your current physical health?

   Poor_____ Unsatisfactory_____ Satisfactory_____ Good_____ Very Good_____

2. Describe any health issues, concerns, or chronic illnesses:_____

_____

_____

_____

_____

3. How often do you exercise?_____
   What type of exercise(s)?_____

4. How do you rate your sleeping habits and quality?

   Poor_____ Unsatisfactory_____ Satisfactory_____ Good_____ Very Good_____

5. How do you rate your appetite and eating habits?

   Poor_____ Unsatisfactory_____ Satisfactory_____ Good_____ Very Good_____

Describe any eating issues:_____

_____

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SOCIAL HISTORY

1. Are you married or in a romantic relationship? No_____ Yes_____
Rate the marriage or relationship on a scale from 1 (poor) to 10 (ideal):_____
Describe the quality or problems of your marriage or relationship:_____
_____
_____
_____

2. Which Social Media platforms do you use, how often do you access these, and how do you feel about them (pleased, stressed, addicted, harassed)?_____
_____
_____
_____

3. What (if any) significant life events, stressors, or changes have you experienced recently or in the last year?_____
_____
_____
_____

4. Are you employed? No_____ Yes_____
How do you feel about the work you do?_____
_____

What are the stressors of your work / job / career?_____
_____

5. Do you consider yourself spiritual, or do you attend a church or practice a religion?_____
_____

STRENGTHS, WEAKNESSES, AND PURPOSE

1. What do you consider to be a strength(s) in character, skills, or competence?
_____
_____
_____

2. What do you consider to be your weaknesses?
_____
_____
_____

3. What do you need to accomplish in or through Therapy?
_____
_____
_____
_____

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