

Client Intake Form

Constance A. Kehrer, Ph.D.
Licensed Psychologist #2551
Phone: 425-301-8832 Fax: 425-458-7522
cakkehrer@gmail.com www.conniekehrerphd.com

Today's Date: _____

Referred by: _____

PERSONAL INFORMATION

Name: _____ Age: _____ Sex: _____

Address: _____ Own/Rent: _____

City, State, Zip: _____ Date of Birth: _____

Home Phone: _____ May I call this number? _____ May I leave a message? _____

Cell Phone: _____ May I call this number? _____ May I leave a message? _____

Email: _____ May I email you appointment reminders? _____

(Note: Email is not considered secure. I use it for appointment reminders & to arrange and modify appointments only.)

Person responsible for bill: _____ Relationship: _____

Address & Phone of responsible party: _____

EMERGENCY CONTACT

Emergency Contact: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Primary Coverage

Name of Insured: _____ Social Security #: _____ DOB: _____

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

Secondary Coverage

Name of Insured: _____ Social Security #: _____ DOB: _____

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

EMPLOYER

Employer: _____ Job Title: _____ From/To: _____

Address: _____

Work Phone: _____ May I call this number? _____ May I leave a message? _____

Previous Employer: _____ Job Title: _____ From/To: _____

EDUCATIONAL HISTORY

History of learning difficulties? _____ Describe: _____

High school: _____ Graduated? _____ Date of graduation: _____

College or Professional School _____ Degree earned and date: _____

College or Professional School _____ Degree earned and date: _____

College or Professional School _____ Degree earned and date: _____

MEDICAL & REFERRAL INFORMATION

Primary Care Physician: _____ Phone: _____

Other Physicians: _____ Phone: _____

May I share session notes with your physicians? _____ **(Note: Insurance requirements may necessitate)**

Who referred you? _____ Relationship: _____

PERSONAL MEDICAL HISTORY

(Note: Many insurance companies and Medicare require that I obtain detailed medical information)

Have you ever had or do you currently have any of the following: (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Head injury with loss of consciousness | <input type="checkbox"/> Urination, bowel problems, constipation _____ |
| <input type="checkbox"/> Intracranial hemorrhage | <input type="checkbox"/> Sexually transmitted disease or HIV _____ |
| <input type="checkbox"/> Memory or cognitive problems | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Meds _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Eating problems or eating disorder _____ |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Sleeping problems (Insomnia, hypersomnia: _____) |
| <input type="checkbox"/> Heart attack/myocardial infarction | <input type="checkbox"/> Sleep apnea (If yes, CPAP use? Y/N _____) |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tobacco use (What, how much: _____) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Current alcohol use: What, drinks per week: _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Past heavy alcohol abuse (List details below) |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Rec drug use: ___ Current ___ Past (List details below) |
| <input type="checkbox"/> Kidney failure/renal disease | <input type="checkbox"/> Substance abuse problem/treatment (List details below) |
| <input type="checkbox"/> Thyroid or adrenal problems | <input type="checkbox"/> Trauma, abuse history: ___ Emotional ___ Physical ___ Sexual |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Self-harm behaviors: ___ Cutting ___ Burning ___ Other |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Suicide attempt (List details below) |
| <input type="checkbox"/> Chronic pain (Where: _____) | <input type="checkbox"/> Psychiatric hospitalization (List details below) |
| <input type="checkbox"/> Eye problems (Glaucoma, etc) | <input type="checkbox"/> Mood problems or mood related diagnosis (List details below) |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Mood, psychiatric problems/diagnoses in family members) |
| <input type="checkbox"/> Peri or post menopausal problems | <input type="checkbox"/> Previous therapy: ___ Individual ___ couples ___ group |

Please provide details for medical issues listed on previous page. Please also list any other significant medical problems not noted above. Attach additional pages if necessary:

Please list all physicians treating current medical conditions: _____

CURRENT MEDICATIONS

Please list all prescriptions, over-the-counter medications, & herbal/vitamin supplements. Please also list prescribing physician, dose and frequency. You may attach a typed list.

CURRENT HOUSEHOLD INFORMATION

Spouse/Partner Name: _____

Spouse/Partner's Employer: _____ Work Phone: _____

Others in home (name): _____ Gender: _____ Age: _____ Relationship: _____

Pets: _____

Unusual household situations: _____

MARITAL HISTORY AND CHILDREN

Please list whether: Single/never married, Married, Separated, Divorced, Widowed, or Unmarried living w/partner: _____

If currently married, marriage date: _____

If living with someone, since when: _____

If widowed, circumstance and date of spouse's death: _____

Previous marriages – Please list name of former spouse(s) and dates married: _____

Children:

Name	Age	Marital Status	Place of residence	Bio/Adopt/Step
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

