Brooke Van Oosbree, PsyD

925-408-2236
drbrookevano@gmail.com
brookevanoosbree.com

Intake Form

Today's Date: _______________

Contact and Demographic Information

Name: ______________________________________ Date of Birth: _______________ Age:______

Gender: ________________________ Biological Sex: ___________________________

Address: ____

____

Primary Phone Number: __________________ Type: *home* | *cell* | *work* | *other*

Secondary Phone Number: __________________ Type: *home* | *cell* | *work* | *other*

May I leave voice messages on your primary number? *y* | *n* secondary number? *y* | *n*

Email: ____

May I contact you via email for administrative matters, such as scheduling? *y* | *n*

How did you hear of my practice?____

Will you be requesting a bill? If yes, please choose one:

☐ Bill is for insurance reimbursement (requires a diagnosis, we will discuss this).

☐ Bill is for flex spending or tax purposes (no diagnosis required).

Emergency Contact Information:

Name:______________________________ Phone:___________________ Relationship:__________

Occupational Status:

Employed | *Unemployed* | *Student* | *Disabled* | *Retired* | *Other*: ______________

Employer/School: ____

Occupation/Field of Study:____

Partnership Status:

Single | *Married/Partnered* | *Separated* | *Divorced* | *Widowed* | *Other*: ______________

Living with Spouse/Partner(s)? *y* | *n* Number of Years Together: ____________

Other identity factors you wish to share (e.g. ethnicity, sexual orientation religious faith, veteran status, disability status, nationality, etc): ____

____

Clinical Information and History

Major reason(s) for seeking help at this time and goals for therapy: ________________________

____

____

Please indicate whether any of the following symptoms/concerns have been present currently (within the last month) or in the past.

	Current	Past		Current	Past
Depression			Alcohol/drug cravings		
Anxiety			Relationship problems		
Panic Attacks			Difficulties at work/school		
Sleep difficulties			Victim of violence/abuse		
Appetite/weight changes			Thoughts of suicide/self-harm		

Please list any previous therapy, including individual, couples, family, or group therapy.

	Year(s)	Provider	Was it helpful?
Individual			
Couples			
Family			
Group			

Have you ever been hospitalized for psychiatric reasons? *y* | *n*

If yes, date(s) and details:____

____

Do you have any previous suicide attempts, self-destructive behaviors, or violence? *y* | *n*

If yes, indicate age, circumstances, and whether it led to hospitalization or legal problems

____

____

Please list any psychiatric medications have taken in the past or are taking currently, including dosages and approximate dates:_______________________________________

____

Please list any other medications you are *currently* taking (including over-the-counter and herbal):____

Do you have any serious or chronic medical conditions (including past surgeries)? *y* | *n*

If yes, date(s) and details:

____

____

Do you have any history of serious head injury, concussions, or seizures? *y* | *n*

If yes, date(s) and details:

____

____

How much/how often do you use the following?

Alcohol ____ per day ____ per wk ____ per month

Marijuana ____ per day ____ per wk ____ per month

Nicotine ____ per day ____ per wk ____ per month

Caffeine ____ per day ____ per wk ____ per month

Please list any other substances you have used within the past year (e.g. hallucinogens, opiates, stimulants, etc.)____

____

Have you or anyone else ever thought that you had a problem with substance use? *y* | *n*

If yes, please describe: ____

Social Information and History

Who is currently living with you? (state the relationship to you):

____

Who did you live with growing up? (state the relationship to you):

____

Where did you live growing up? ____

Do you know of any family members or relatives who have had mental health concerns or problems with substance use? *y* | *n*

If yes, please describe:____

____