Intake: Client Psychosocial History and Status

Name: ______________________________________ Birthdate: __________________ Age: ___________

Address: _____________________________ City/State: _________________________ Zip:___________

Primary Phone: ________________________ Secondary Phone: ________________________

Emergency Contact: ________________________Cell: __________________ Home: _________________

Briefly describe your reason for coming to see me: ____

____

____

How did you hear about me? ____

What is your religious affiliation? ____ None ❑

Education/Degrees: ____

Occupation:____ How Long? ______________________

Place of Employment: _____________________________________ How Long? ______________________

If not employed, how long has it been since you worked? ____

What kind of job did you have? ____

What caused you to stop working? ____

Relationship Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Living Together

Current and Past Significant Relationships

To Whom	Length of Relationship	Ending Date of Relationship	Children together

Briefly describe your current relationship: ____

____

____

Age of current spouse/partner: ______________________ Religion: __________________________________

Education/degrees? ______________________________ Occupation: __________________________________

Is he/she currently employed? ❑ Yes ❑ No How Long? ______________________________________

Has your partner had previous significant relationships? ❑ Yes ❑ No Number of times: ___________

How long since his/her last one? ______________________

Number of children from previous relationship: __________ Ages of children: _______________________

With whom are you currently living?

Name	Relationship	Age	Use of Alcohol/Drugs?	How do you get along?

Extended Family: Parents, Siblings, And Others Close To You

Name	Relationship	Age	Occupation	Challenges: i.e. Alcohol, History Mental Illness

How was it to grow up in your family? ____

____

____

Medical Information

When were you last examined by a physician? ____________ Name of Doctor: ________________________

List any health problems for which you currently receive treatment: ____________________________________

____

List any past health problems including accidents: ____

____

List any medications you currently take: ____

Women only:

How many pregnancies have you had? __________ Are you pregnant now? ❑ Yes ❑ No

Any miscarriages or abortions? ❑ Yes ❑ No ________________________ How many?

Men and women:

Are you sexually active? ❑ Yes ❑ No Beginning at what age? ____

Do you use birth control methods? ❑ Yes ❑ No If yes, what? __________________________________

Have you ever had concern about eating habits? ❑ Yes ❑ No

Psychological/Emotional Information

Have you ever sought help or been treated for psychological or emotional reasons? ❑ Yes ❑ No

If so, when and where? ____

Was it helpful? ____

Have you ever thought about suicide? ❑ Yes ❑ No If so, did you have a plan? ❑ Yes ❑ No

Have you ever attempted suicide? ❑ Yes ❑ No If so, how many times? _________________________

Alcohol/drug use history

Do you feel you have a drug or alcohol problem? ❑ Yes ❑ No

Have you ever had any previous treatment for drug / alcohol abuse? ❑ Yes ❑ No

If so, when and where? ____

List all drugs, including alcohol, that you currently use, or have used in the last year (indicate frequency and amount): ____

____

____

Legal

Please list and describe any arrests or legal problems (including driving violations): ____________________

____

____

Circle any problem that pertains to you at the present:

Anger	Education	Sexual Problems	Work
Drug Use	Loneliness	Bowel Troubles	Relationship
Fatigue	Ambition	Stomach Problems	Divorce
Finances	My Appearance	Suicidal Thoughts	Future
Friends	Concentration	Nightmares	Temper
My thoughts	Parenthood	Health Problems	Age
Nervousness	Relaxation	Making Decisions	Stress
Self-esteem	Sexual Orientation	Physical Abuse	Anxiety
Separation	Energy	Inferiority	Appetite
Sexual Abuse	Children	Career Choices	Weight
Shyness	Legal Matters	Self Control	Memory
Sleep	Under / Over-eating	Alcohol Use	Overeating
Unhappiness	Depression	Headaches	Fears
Other: ____________			

Circle everything that has happened to you in the past three years:

Death of a spouse/partner	Relationship Problems	Changes in relationship status
Death of another family member	Family Problems (Children, in-laws)	Loss of Job
Major illness or injury–yourself	Financial Problems	Move to another city or state
Major illness or injury–family member	Legal Problems	Other: ________________

Please list any additional information that you feel may be helpful for me to know about you:

____

____

____

____

____

____

Office Policy and Financial Responsibility Statement

I UNDERSTAND THAT:

- Therapy sessions are **50 minutes** in length and are billed at **$145.00 per session.** Extended sessions are billed proportionately. Payment of cash, check or credit card is due at each visit.
- Sessions of late arrivals will end on time and be billed the full fee.
- The rate of $145.00 will also apply to time spent on providing special services, such as telephone sessions, phone calls, case consultations, and time spent discussing treatment with other authorized professionals.
- Jeri Kramer does not communicate with clients via text messages or social media platforms. Communication outside of therapy sessions is best done via her encrypted email account or phone.
- With the exception of Mayo Clinic Health Solutions, Jeri Kramer does not participate with third party payers, such as managed care organizations and insurance companies. By signing this form, I am agreeing to pay the entire bill at the time of service. If requested, I may receive a "super-bill" as a receipt to submit to a third party payer.
- **I must give 24-hour notice of appointment cancellation or I will be billed in full. MONDAY appointments must be cancelled by Friday at 5:00pm.**

initial __________

I understand that I am financially responsible for any and all charges incurred for the treatment of the above-named. I have read the above office policy regarding length of sessions, late arrivals, charges, missed appointments, etc. **I understand and agree to the stated terms.**

____ ___________________________

Signature of Client (or Parent of Minor child) Date

Jeri L Kramer, Psy.D. 602-690-7763

Website: www.jerikramer.com Email: jerikramerpsyd@hushmail.com

Consent for Evaluation and Treatment

Your signature below indicates that you have received a copy of the INFORMED CONSENT from my website (www.jerikramer.com), and that you agree to abide by these terms during our professional relationship.

____

Name of client

____

Signature of client (or guardian if client is a minor)

____

Date