Brianne DeWitt Goudelock, Ph.D.
Licensed Clinical Psychologist, CA #PSY 24432

Intake Form (Confidential)

Name: ____ **Gender:** _________ **Date:** __________________

Date of Birth: ____________________ **Age:** _________ **Occupation:** _______________________________

Are you a Veteran? _______________________

If/when necessary, I may be contacted via:

Mailing Address:____

City/State: ____

Primary Phone (Home/Cell): (_____)______________________________

May I leave a voicemail at this number? **Yes / No

** If no, where can I leave a voicemail? (_____)_________________________________

E-Mail Address (optional)**: ___________________________________

** By providing my email address, above, I am acknowledging that I understand that E-Mail is not a confidential mode of communication. If privacy must be guaranteed or the matter is urgent, I will contact Dr. DeWitt Goudelock by phone.

If you are a minor (under 18 years of age), please list contact information for your parent(s)/guardian(s):

Name(s): ____

Mailing Address:____

Primary Phone (Home/Cell): (_____)_________________

In an emergency, Dr. DeWitt Goudelock may contact:

Name: __________________________________ Phone: (_____)____________________

Relationship to You:______________________ Address:__________________________

PREVIOUS COUNSELING

Have you had any counseling or psychotherapy elsewhere? ☐ Yes ☐ No

If you answered "Yes" above, please answer the following:

Therapist Name: ________________________________ Number of Sessions: ________

Therapist Location: _____________________________ Approximate Date of Last Visit: ________

SOCIAL SYSTEM

With whom do you usually discuss problems or concerns? ________________________________

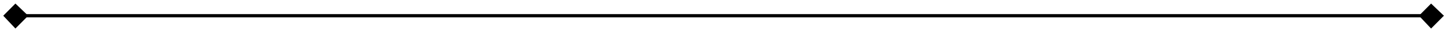
How many of your friends live in the local area? _______________

What community or school organizations do you currently belong to (e.g., sports, church, political)?

____

____

____



INITIAL CONCERNS

Please summarize the concern(s) that have brought you to seek counseling:

____

____

____

MEDICAL/PSYCHIATRIC INFORMATION

Please list all <u>prescribed</u> or <u>over the counter</u> medications you use (including dosages, if known):

____

____

Have you ever been hospitalized for psychiatric concerns? ☐ Yes ☐ No

If "Yes," please list the reason(s): ______________________________________

Are you currently under the care of a physician/psychiatrist/other medical care? ☐ Yes ☐ No

If you answered "Yes," above, please answer the following:

Date of Last Visit: ______________________________

Provider/Agency Name: ______________________________

Provider/Agency Location: ______________________________

Purpose: ______________________________

HEALTH INSURANCE PROVIDER: ______________________________

Policy Number: ______________________________

I will be paying for my session today by: ☐ Check ☐ Cash

☐ Other (e.g., PIA, as arranged w/Dr. DeWitt Goudelock)

FAMILY INFORMATION

Please provide the following information regarding members of your family/household…

Relationship To You (e.g. Father, Sister, etc.)	Age	Occupation	Education	Status	☑
				Single	
				Married/Partnered	
				Divorced/Separated	
				Deceased	
				Single	
				Married/Partnered	
				Divorced/Separated	
				Deceased	
				Single	
				Married/Partnered	
				Divorced/Separated	
				Deceased	
				Single	
				Married/Partnered	
				Divorced/Separated	
				Deceased	
				Single	
				Married/Partnered	
				Divorced/Separated	
				Deceased	
				Single	
				Married/Partnered	
				Divorced/Separated	
				Deceased	

Is there any family history of mental health problems? If so, please explain:

____

____

Please estimate how many hours per day you spend using electronic media:

Browsing: _____ Facebook: _____ Twitter: _____ Gaming: _____

Texting: _____ Work/School: _____ YouTube: _____ Other (please specify): _____
____

Do you feel you have difficulty keeping your technology use balanced and healthy? ________

If you feel you have difficulty, please explain:

____

REFERRAL INFORMATION

How did you hear about my services?

____

____

PROBLEMS LIST

Please circle the primary concerns that brought you to therapy:

Job/Academic Issues	Finances	Adjustment to a Life Change
Alcohol/Drug Use	Body Image/Eating	Anxiety/Nervousness
Confusion about Beliefs	Relationship Concerns	Difficulty Focusing
Military Experiences	Sadness/Depression	Death of Loved One
Hopelessness	Sleep Concerns	Harming Self (cutting, burning)
Experiencing Things Others Don't	Sexuality	Identity
Addiction (media, pornography)	Intrusive/Unusual Thoughts	Anger Concerns
Legal Issues	Loneliness	Mood Swings
Problem Maintaining Relationships	Perfectionism	Physical/Health Problems
Concerns Related to Fertility	Religious/Spiritual Concerns	Obsessive Thoughts
Behaviors Seem Uncontrollable	Ethnic Identity Concerns	