AMY STEINHAUER
RELATIONAL PSYCHOTHERAPY

Confidential Psychotherapy Intake Form

Date: _____

Identification & Contact Information

Name: _____ Birthdate: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ ❑ May leave general message ❑ May leave private message

Cell Phone: _____ ❑ May leave general message ❑ May leave private message

Work Phone: _____ ❑ May leave general message ❑ May leave private message

Email: _____ ❑ May email general message* ❑ May email private message*

*I understand that confidentiality cannot be guaranteed for email, as contents may be intercepted during transmission.

Referred by: _____

❑ Amy Steinhauer may thank my referral source for referring me _____ please initial

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Fees & Insurance

Fee: $180

❑ I request a monthly statement that I may use to seek reimbursement from my insurance plan.

Please check one:

❑ I am a Medicare beneficiary ❑ I am not a Medicare beneficiary _____ please initial

❑ I am not a Medicare beneficiary but expect to become one in the next year_____ please initial

Self-Identification

Gender: _____ Preferred Pronoun: _____ Native Language: _____

Ethnicity/Cultural Identification: _____ Country of Birth: _____

Sexual Orientation: _____ Relationship Status: _____

Religious/Spiritual Affiliation if any: _____ Occupation: _____

Medical

Current medical conditions or health issues: _____

Significant past medical problems: _____

Current medication/drugs/supplements: _____

Primary Care Physician: _____ Phone: _____

Would you like me to contact your doctor to coordinate care? ❑ Yes ❑No ❑If needed

Mental Health

Do you currently have/see a psychiatrist? ❑ Yes ❑ No If yes, who: _____

Do you currently have/see another therapist? ❑ Yes ❑ No If yes, who: _____

Please check if you are currently or recently experiencing any of the following (please ask if you need clarification):

- ❑ Feeling depressed, sad or numb
- ❑ Feeling keyed up or on edge
- ❑ Irritable or angry (often)
- ❑ Frequent crying
- ❑ Sleep trouble
- ❑ Speedy/can't slow down
- ❑ Anxiety or panic
- ❑ Obsessions or compulsions
- ❑ Flashbacks or other PTSD symptoms
- ❑ Nightmares
- ❑ Spacing out
- ❑ Self-injury
- ❑ Eating issues: restricting, bingeing, purging, compulsive eating
- ❑ Substance use concerns
- ❑ Suicidal thoughts or feelings
- ❑ Suicidal plans or intent
- ❑ Homicidal thoughts or feelings
- ❑ Homicidal plans or intent
- ❑ Relationship concerns
- ❑ Sexual concerns
- ❑ Other 'symptom' concerns: _____

Please list any psychiatric hospitalizations (place, approximate date): _____

_____

History

Were you physically abused as a child? ❑ yes ❑ no

Were you sexually abused, molested, or inappropriately touched as a child? ❑ yes ❑ no

Were you emotionally or verbally abused as a child? ❑ yes ❑ no

Were you physically or emotionally neglected as a child? ❑ yes ❑ no

Have you been physically abused or assaulted as an adult? ❑ yes ❑ no

Have you been sexually abused, assaulted, or coerced as an adult? ❑ yes ❑ no

Have you been emotionally or verbally abused as an adult? ❑ yes ❑ no

Have you experienced other traumas as a child or adult? ❑ yes ❑ no

Significant mental health issues in family: _____

Substance abuse history of family: _____

Current quality of relationships with family of origin: _____

Presenting Concerns

Please list your primary concerns or goals for entering psychotherapy at this time: _____

_____

_____

_____

_____

_____

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