Daniel S. Sokal, LCSW

Psychotherapy

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Intake Form

Welcome! In order to identify how I can best help you, I will need to know about you and your life. Please know that this is your information and you decide how much you are willing to share with me and when. However, please know that the more information you are willing to give will help us spend our time together more effectively. Keep in mind that all of your information will be kept confidential and I follow all regulations set forth by H.I.P.P.A. and the code of ethics for the National Association of Social Workers. After completing this form, you can either mail or email it to my office. Otherwise, you can simply bring it with you to our first session together.

Daniel S. Sokal, LCSW phone: 917-327-0425 or 315-416-6220

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Name/Address _____
Phone_____ Date of Birth _____

Primary Care Physician_____ Phone:_____

Do you give permission for ongoing regular updates to be provided to your primary care physician? _____

Therapist:_____ Phone:_____

Psychiatrist: _____ Phone:_____

What is the problem for which you are seeking help?

_____

_____

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry

( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks

( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance

( ) Loss of interest ( ) Increased libido ( ) Hallucinations

( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness

( ) Change in appetite ( ) Excessive energy ( ) Excessive guilt

( ) Increased irritability ( ) Fatigue ( ) Crying spells ( ) Decreased libido

( ) Other:_____

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts?
_____

When was the last time you had thoughts of dying?
_____

Has anything happened recently to make you feel this way?
_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better?
_____

Have you ever thought about how you would kill yourself?
_____

Is the method you would use readily available?
_____

Have you planned a time for this?
_____

Is there anything that would stop you from killing yourself?
_____

Do you feel hopeless and/or worthless?
_____

Have you ever tried to kill or harm yourself before?
_____

Do you have access to guns? If yes, please explain.
_____

Has anyone you have known took their own life?
_____

Past Medical History:

Allergies_____

Current Weight _____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)
Medication Name Total Daily Dosage Estimated Start Date:
_____
_____
_____
_____
_____
_____
_____
_____

Current over-the-counter medications or supplements:
_____
_____

Current medical problems:
_____
_____

Past medical problems, nonpsychiatric hospitalization, or surgeries:
_____
_____

Females only:

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.

How many times have you been pregnant? _____ How many live births? _____

Date and place of last physical exam:
_____

Personal and Family Medical History:
When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____
_____

Past Psychiatric History:
Outpatient treatment ( ) Yes ( ) No
If yes, Please describe when, by whom, and nature of treatment.
Reason Dates Treated By Whom:

_____
_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.
Reason Date Hospitalized Where:

_____
_____
_____
_____

Past Psychiatric Medications:
If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were.

_____
_____
_____
_____

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for:

- Bipolar disorder ( ) Yes ( ) No
- Schizophrenia ( ) Yes ( ) No
- Depression ( ) Yes ( ) No
- Post-traumatic stress ( ) Yes ( ) No
- Anxiety ( ) Yes ( ) No
- Alcohol abuse ( ) Yes ( ) No
- Anger ( ) Yes ( ) No
- Other substance abuse ( ) Yes ( ) No
- Suicide ( ) Yes ( ) No
- Violence ( ) Yes ( ) No

If yes, who had each problem?

_____
_____
_____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?
_____
If yes, where were you treated and when?
_____
_____
_____

- How many days per week do you drink any alcohol? _____
- What is the least number of drinks you will drink in a day? _____
- What is the most number of drinks you will drink in a day? _____
- In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
- Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
- Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
- Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
- Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
- Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones?
_____
_____

Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long?
_____
_____
_____

Check if you have ever tried the following:
Yes or No: If yes, how long and when did you last use?

( ) Methamphetamine
( ) Cocaine
( ) Stimulants (pills)
( ) Heroin
( ) Marijuana
( ) LSD or Hallucinogens

_____
_____
_____
_____
_____
_____

Pain killers (not as prescribed)
_____

Methadone: _____

Tranquilizer/sleeping pills: _____

Alcohol: _____

Ecstasy: _____

Other: _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? **( )** Yes **( )** No
How many packs per day on average? _____ How many years? _____
In the past? **( )** Yes **( )** No
How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco:
Currently? **( )** Yes **( )** No
In the past? **( )** Yes **( )** No
What kind? _____
How often per day on average? _____
How many years? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up?
_____

List your siblings and their ages:
_____
_____
_____

What was your father's occupation?
_____

What was your mother's occupation?
_____

Did your parents' divorce? ( ) Yes ( ) No
If so, how old were you when they divorced? _____

Describe your father and your relationship with him:
_____
_____

Describe your mother and your relationship with her:
_____
_____

How old were you when you left home?
_____

Has anyone in your immediate family died?
_____

Who and when?
_____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect?
( ) Yes ( ) No.
Please describe when, where and by whom:
_____
_____
_____

Educational History:
Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____
Major? _____

What is your highest educational level or degree attained?
_____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation?
_____
Where do you work? _____
Have you ever served in the military? _____
If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No
Other type discharge: _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed
How long? _____

If not married, are you currently in a relationship? ( ) Yes ( ) No
If yes, how long? _____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?

( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation?
_____

Describe your relationship with your spouse or significant other:
_____
_____

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? _____

How long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:
_____
_____

Describe your relationship with your children:
_____

List everyone who currently lives with you:
_____
_____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like for me to know?
_____
_____
_____
_____

Signature_____Date_____

Guardian Signature (if under age 18) _____ Date:_____

Emergency Contact _____Telephone # _____