



Heller Psychological Services, P.C.
 Child/Adolescent/Adult Psychotherapy & Consulting
 Lindsay Heller, Psy.D., Clinical Psychologist / PSY21400
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INTAKE FORM

Date _____ Last Name _____ First Name _____

Address _____

City _____ State _____ Zip _____

Sex (M/F) _____ Birth Date _____ SS# _____

May I contact you by email for scheduling purposes? _____ Mailing list? _____

Email Address: _____

Home Phone _____	Can I call you here? _____	Can I leave a message? _____
Cell Phone _____	Can I call you here? _____	Can I leave a message? _____

How did you hear about Dr. Monaco? _____

Has anyone urged you to come here? _____

Briefly tell me about the issues/concerns that have brought you here.

Please check any current or past issues that still affect you.

- ___ Eating Disorders
- ___ Academic Issues
- ___ Childhood Abuse (i.e. physical, sexual, emotional)
- ___ Stress/Anxiety
- ___ Phobias (type: _____)
- ___ Alcohol/Other Drug Use
- ___ Sexual Assault/Rape
 - ___ recently (when: _____)
 - ___ in the past
- ___ Death of a someone close
 - ___ recently (when: _____)
 - ___ in the past
- ___ Family Issues (i.e. divorce, alcoholism, domestic violence)
- ___ Other: _____

- ___ Pregnancy Issues
- ___ Spiritual Concerns
- ___ Depression
- ___ Pornography
- ___ Sexual Identity Issues
- ___ Relationship Concerns
 - ___ family
 - ___ friend
 - ___ parent
 - ___ significant other
 - ___ roommate
 - ___ other: _____
- ___ Suicidal Thoughts

YOUR HISTORY...

Current medical problems _____

Current medications (*all, including herbal*) _____

Are you currently working with any Personal Physician? _____ Phone Number: _____

Name _____ What for? _____

Have you been on any medications in the past for mental health issues? _____

(Please list) _____

Have you previously seen a therapist? _____ Who/Where? _____

How long ago? _____ For what types of issues? _____

Are you currently seeing a therapist? _____

Have you ever been hospitalized for physical or mental health issues? (*Briefly describe*) _____

Have you had any previous suicide attempts? _____ (*Briefly describe*) _____

If you are currently experiencing any of the following symptoms, please rate them using the number key below.

<i>Never = 0</i>	<i>Seldom = 1</i>	<i>Often = 2</i>	<i>Always = 3</i>
_____ Difficulty concentrating		_____ Memory loss or blackout	
_____ Crying		_____ Difficulty sleeping	
_____ Missing classes		_____ Stealing	
_____ Feeling helpless		_____ Anger	
_____ Feeling uptight		_____ Eating binges	
_____ Worrying		_____ Drinking heavily	
_____ Feeling hopeless		_____ Other drug use	
_____ Feeling afraid		_____ Guilt feelings	
_____ Lying to others		_____ Withdrawing socially	
_____ Feeling out of control		_____ Sexual preoccupation	
_____ Feelings of self-doubt		_____ Physical symptoms (<i>i.e. headaches, digestive</i>)	
_____ Injuring self		List: _____	
_____ Nervous around others		Have you seen a health care provider for these? _____	
_____ Suicidal Thoughts		Other: _____	

Would you be interested in a counseling group? _____ For what issues/topics? _____

Please use the scale below to answer the following questions.

4=True to a great extent

3=Mostly true

2=Somewhat true

1=Not at all true

My current concerns affect my success in life. _____

My current concerns affect my ability to interact and connect with others. _____

I am optimistic that I will be able to make some positive changes as a result of counseling. _____