

MARIE MARGENAU-SPATZ, Ph.D.

Patient Intake Information

Strictly Confidential

Thank you in advance for completing this Intake form. Please answer the information requested, print clearly and answer all sections completely.

Section I.

Intake Date: (Month / Day / Year)

Patient Name & Address & Telephone:

Last: First: Middle: Preferred Name:

Address: Apartment / Suite Number:

City/State/Zip:

Telephone: Day/Work: () Eve/Home: () Fax: ()

Mobile: () Vacation Phone: () Email:

Emergency Notification:

Name: Relationship:

Telephone:

Bill To: (If someone other than you is responsible for payment)

Name: Relationship to Patient: Telephone:

Address: Apartment / Suite Number:

City/State/Zip:

Referral Source:

Name:

Relationship to Patient:

Treatment/Service: (Please leave blank)

90806 [] 90808 [] 90847 []

Diagnosis: (Please leave blank)

- I. II. III. V.

Date of Birth:

Present Age:

Social Security #:

Occupation:

Employment: Please [x] check one: Self-Employed [] Employed by other []

Business or Company Name:

Address:

City/State/Zip:

Patient Intake Information continues on next page.

Marital Status:

Please check one: Single Married Domestic Partner Divorced Separated Widow

Family:

Parents' Names & Ages:

Spouse's Name & Age:

Child's Name(s) & Ages:

Sibling Name(s) & Ages:

Present Concerns/Issues:

Briefly, please state the reasons for treatment [\(Use additional space as needed\)](#):

Medical Health:

Indicate your general medical health, please check one:

Excellent Good Fair Poor


Present Medical Problems (if any):

Physician Care: [\(If under physician's care please indicate the following\)](#):

Physician's Name:

 Address:

City/State/Zip:

 Telephone:

Medication:

Please check all that applies: None Psychotropic Medical Other

If you are taking medicine(s), please indicate the following:


Name Of Medication	Current Dosage / Frequency	Start date	Side Affects
			No <input type="checkbox"/> Yes <input type="checkbox"/>
			No <input type="checkbox"/> Yes <input type="checkbox"/>
			No <input type="checkbox"/> Yes <input type="checkbox"/>
			No <input type="checkbox"/> Yes <input type="checkbox"/>

Dr. Contact:

If you have previously been in psychotherapy, please state the therapist's name, address & telephone number and state reasons for treatment and dates.

Name of Psychotherapist:

 Address:

 Telephone:

City/State/Zip:

Reason:

Dates:

Availability:

Please indicate the range of day and evening hours (starting times and leaving times) that you are available for session time Monday through Thursday. Appointments begin at 10:00am.

	Monday	Tuesday	Wednesday	Thursday
Daytime				
Evening				

Fee Rate / Session Time: (Please leave blank)

First Appointment Date: (Please leave blank)

Fee: 45 min. ; 60 min. ; 90 min. ; Other .

Credit Card Information: (if applicable)

Please check one:

Visa MasterCard American Express

Name on Card:

Credit Card Number:

Credit Card Expiration Date:

I authorize Dr. Marie Margenau-Spatz to charge my credit card account as payment for therapy session(s).

Print name as it appears on credit card: _____

Signature: _____

Please check "No" or "Yes" for questions 1 - 6 below:

- Do you have a problem with drugs or alcohol? If yes, state the problem. No Yes
- Have you ever attempted suicide or homicide? If yes, give the details. No Yes
- Are you presently feeling suicidal or homicidal? If yes, describe your feelings. No Yes
- Have you ever been hospitalized for mental illness or drug abuse? If yes, state the problem, name and location of hospital and dates. No Yes
- Are you taking medication for psychological problems? If yes, list the medicine names and dosage. No Yes
- Do you have a history of mental illness or substance abuse? If yes, state the problem and dates. No Yes

Section II.

Please fill out this section. Your responses to the following questions will help me provide the most effective services to you. Thank you for your cooperation. Your answers to these questions are strictly confidential.

Assessment

Please assess how your current symptoms have affected the level of functioning in the following categories.

Please rate how much you were affected by the following in the week before your first therapy appointment.

	Not at all	Mildly	Moderately	Severely	Extremely
Concerns about your body or physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts or behaviors you do over and over again	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusually high energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling sad, blue, or depressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety, 'nerves,' or tension.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger, hostility, or irritability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fears of things or places.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beliefs that others want to hurt you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking too much or using drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unreal, strange, or bizarre thoughts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check the box which best describes how well you are doing on your job or at school.

0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
Not Working	Can not Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Please check the box which best describes how well you are doing in your marital / significant other relationship.

0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>
Not Applicable	Can not Function		Serious Problems		Moderate Problems		Mild Problems		No Problems

Section II continues on next page.

Please check the box which best describes how well you are doing in your family relationships.

- 0 Not Applicable 1 Can not Function 2 3 Serious Problems 4 5 Moderate Problems 6 7 Mild Problems 8 9 No Problems

Please check the box which best describes how well you are doing in your social relationships.

- 0 Not Applicable 1 Can not Function 2 3 Serious Problems 4 5 Moderate Problems 6 7 Mild Problems 8 9 No Problems

Please check the box which best describes your feelings about your financial situation.

- 1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your general happiness and well-being.

- 1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning relating to hobbies, interests, play activities.

- 1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning in activities of daily living (i.e., personal hygiene, bathing, etc.)

- 1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning re: physical health.

Weight loss _____ lbs. Weight gain _____ lbs. Current weight _____ lbs. Height _____

- 1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning in eating habits.

Weight loss _____ lbs. Weight gain _____ lbs. Current weight _____ lbs. Height _____

1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning in sleeping habits.

Difficulty falling asleep Difficulty staying asleep Early morning awakening

1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning in sexual functioning.

1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning in ability to concentrate.

1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Please check the box which best describes your current functioning in ability to control your temper.

1 Very Poor 2 3 4 5 6 7 8 9 Excellent

Thank you for taking the time to complete this Intake Information Form.
The information you have given will be kept in the strictest confidence.

Dr. Marie Margenau-Spatz

End of Patient Intake. The following page is for administrative use only.

Section III.

Functioning

Categories	Current Functioning									
Scale 0-9*	#0 Not Applicable	#1 Can Not Function	#2	#3 Serious Problems	#4	#5 Moderate Functioning	#6	#7 Above Average Functioning	#8	#9 Excellent Functioning
1. *Job or at School										
<input type="checkbox"/> Disability Leave <input type="checkbox"/> Job Jeopardy										
Scale 0-9*	#0 Not Applicable	#1 Can Not Function	#2	#3 Serious Problems	#4	#5 Moderate Functioning	#6	#7 Above Average Functioning	#8	#9 Excellent Functioning
2. *Marital / Significant Other										
3. *Family Relationships										
4. *Social Relationships										
Scale 1-9		#1 Very Poor	#2	#3	#4	#5	#6	#7	#8	#9 Excellent
5. Financial Situation										
6. General Happiness / Well Being										
7. Hobbies / Interests / Play Activities										
8. Daily Living (i.e., personal hygiene, bathing, etc.)										
<input type="checkbox"/> Weight Loss _____ lbs. <input type="checkbox"/> Weight Gain _____ lbs. <input type="checkbox"/> Current Weight _____ lbs. Height _____										
Scale 1-9		#1 Very Poor	#2	#3	#4	#5	#6	#7	#8	#9 Excellent
9. Physical Health										
10. Eating Habits										
11. Sleeping Habits										
<input type="checkbox"/> Difficulty Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Early Morning Awakening										
Scale 1-9		#1 Very Poor	#2	#3	#4	#5	#6	#7	#8	#9 Excellent
12. Sexual Functioning										
13. Ability to Concentrate										
14. Ability to Control Your Temper										
<p>Risk Assessment (Check all that apply)</p> <p>Suicidality: <input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior Attempt Date _____</p> <p>Homicidality: <input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior Attempt Date _____</p> <p>Other Risk Behaviors</p>										