Brian Razzino, Ph.D., PC and Associates
Initial Intake Form

Name _____ Age_____

Birthdate _____

Address _____

City _____ State _____

Zip _____

Home Phone _____Work Phone _____

Cell Phone:_____

Occupation _____

Employer _____

Marital Status _____

Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____

Religion _____

Name of Closest Friend/Relative _____

Phone _____

Address _____ City _____

State _____Zip _____

There are times when prior medical and psychological records will be requested.
Please make sure that all information given below is correct.

Do You Smoke?_____How Much?_____Do You Drink?_____ How Much? _____Do You Take Drugs?_____If yes, what kind? _____

How often?_____Last Medical Examination_____

Reason _____

Are You Now Under a Doctor's Care?_____If yes, Doctor's name:

_____

Reason for Doctor's Care:

_____

Are You Taking Any Medication?_____If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness?

Describe:_____

Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe:

_____

Any Previous Therapy/Counseling? _____If Yes, Name and Phone Numbers of Therapists: _____

When and Number of Sessions:

_____

Type of Therapy/Counseling:

_____

How referred to Us:

_____

What do you Wish to Achieve with Therapy? _____

_____

How will you know it has been achieved?

_____

Check Any of the Following That May Apply to You:

☐ Headache	☐ Inferiority Feelings	☐ Shy With People
☐ Dizziness	☐ Feel Tense	☐ Can't Make Friends
☐ Fainting Spells	☐ Feel Panicky	☐ Afraid Of People
☐ No Appetite	☐ Fears and Phobias	☐ Home Conditions Bad
☐ Over-Eating	☐ Obsessions	☐ Unable To Have A Good Time
☐ Stomach Trouble	☐ Depressed	☐ Always Worried About Something
☐ Bowel Disturbances	☐ Suicidal Ideas	☐ Don't Like Weekends/Vacations
☐ Always Tired	☐ Take Tranquilizers	☐ Can't Make Decisions
☐ Always Sleepy	☐ Alcoholism	☐ Over-Ambitious
☐ Unable To Relax	☐ Dangerous Drugs	☐ Financial Problems
☐ Insomnia	☐ Allergy	☐ Gambling
☐ Recurrent Dreams	☐ Asthma	☐ Job Problems
☐ Nightmares	☐ Homosexuality	☐ Can't Keep A Job
☐ Hallucinations	☐ Sexual Problems	☐ Other _____

INITIAL QUESTIONNAIRE FORM

Name: _____ **Date:** _____

Please read and rate your present concern about each item.

PLACE AN "X" NEXT TO THE MOST APPROPRIATE NUMBER.

1. Do you often feel sick, tired, stressed out or in pain?

None		Some		Much
1	**2**	**3**	**4**	**5**

2. Are you concerned about your diet, weight or level of exercise?

None		Some		Much
1	**2**	**3**	**4**	**5**

3. Do you have concerns about your social life and relationships with peers?

None		Some		Much
1	**2**	**3**	**4**	**5**

4. Are you concerned about the consequences of your drug or alcohol use (self or others)?

None		Some		Much
1	**2**	**3**	**4**	**5**

5. Are you concerned about feeling sad, depressed, lonely or hopeless?

None		Some		Much
1	**2**	**3**	**4**	**5**

6. Do you have concerns about harming yourself or someone else?

None		Some		Much
1	**2**	**3**	**4**	**5**

7. Do you have concerns regarding your sexuality or sexual experiences?

None		Some		Much
1	**2**	**3**	**4**	**5**

8. Do you have concerns about having been or presently being hurt, mistreated or abused by others?

None		Some		Much
1	**2**	**3**	**4**	**5**

9. Are you concerned about your relationship with your family?

None		Some		Much
1	**2**	**3**	**4**	**5**

10. Do you have concerns about your school work, performance in class or career choice?

None		Some		Much
1	**2**	**3**	**4**	**5**

11. Do you have concerns about your learning style?

None		Some		Much
1	**2**	**3**	**4**	**5**

Describe in your own words, your reason for coming to our service:

_____

Patient Name

_____

Instructions

Read each sentence carefully. For each statement, place an "x" in the column that best

Age _____

Sex _____

Date _____

corresponds to how often you have felt that way during the past two weeks. For statements 5 and 7 if you are on a diet, answer as if you were not.

Please check a response for each of the 20 items.

		None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1	I feel downhearted, blue, and sad				
2	Morning is when I feel the best				
3	I have crying spells or feel like it				
4	I have trouble sleeping through the night				
5	I eat as much as I used to				
6	I enjoy looking at, talking to, and being with attractive women/men				
7	I notice that I'm losing weight				
8	I have trouble with constipation				
9	My heart beats faster than usual				
10	I get tired for no reason				
11	My mind is as clear as it used to be				
12	I find it easy to do the things I used to do				
13	I am restless and can't keep still				
14	I feel hopeful about the future				
15	I am more irritable than usual				
16	I find it easy to make decisions				
17	I feel that I am useful and needed				
18	My life is pretty full*				
19	I feel that others would be better off if I were dead				
20	I still enjoy the things I used to do				
		None or a little of the time	Some of the time	Good part of the time	Most or all of the time