Registration Data
Carole Stokes-Brewer, PhD, LISW-S

Name_____
(Last) (First) (Middle Initial)

Home Address_____City_____State_____Zip_____
Home Phone: ( ) _____ - _____ May we leave a msg? Yes ___No ___
Work Phone: ( ) _____ - _____ May we leave a msg? Yes ___No ___
Mobile: ( ) _____ - _____ May we leave a msg? Yes ___No ___
E-mail: _____ May we email you? Yes ___No ___

Marital Status (circle one) M S W D Sep. Date of Birth_____

Occupation_____Employer_____

Name of person responsible for your account_____

Their Date of Birth_____Their Address_____

Their Employer_____
In whose name is the insurance policy?
Insurance Company #1 _____
Insurance Company #2 _____
Who referred_____

Number of children _____ Number of children at home _____

Have you had previous psychotherapy? Yes ___ No ___ Previous therapist's name_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? Yes ___ No ___

If Yes, please list: _____

If no, have you been previously prescribed psychiatric medication? Yes___ No ___

If Yes, please list: _____

RELEASE & AGREEMENT

1. **I understand that I am financially responsible for ALL charges whether or not covered by my insurance policy.**

2. **I authorize and request payment of medical benefits directly to: Carole Stokes-Brewer.**

3. **I authorize release of any medical information necessary to process my insurance claim(s).**

4. **Any unpaid balance will be subject to collections.**

5. **I have received and been given an opportunity to read a copy of Dr. Carole Stokes-Brewer's Notice of Privacy Practices.**

_____ _____/____/_____
Patient signature **Date of signature**

Name_____**Date**_____

INTAKE FORM

All of the information that you provide in this intake is confidential and cannot be released without your consent.

What is the reason that you're attending therapy at this time?

HEALTH & WELLNESS

Do you have any physical health problem(s) Y ___N___ If yes, list condition(s):

List all medications you are currently taking: (prescribed, over the counter, and others). Use back of form if necessary

Medication **Dosage** **Taken for** **When started**

How many times per week do you exercise? _____
Approximately how long each time? _____

Menopause (Check the symptoms that apply to you)

Hot flashes___ Insomnia___ Fatigue___ Memory Loss___ Mood Swings___
Irregular Menses___ Painful Intercourse___ Increased Libido___
Decreased Libido___ Disturbed Sleep Pattern

Current physician or medical agency:

Name_____ Phone_____

Name_____ Phone_____

BEHAVIORAL HEALTH
Check any of the following that you currently experience:

Sleep disturbance___ Appetite disturbance___ Fatigue___ Poor concentration___ Memory problems___ Depression___ Suicidal thoughts___ Suicidal plan___ Homicidal thoughts___ Excessive anxiety___
Panic attacks ___ Frequent anger/Irritation ___ Extreme depressed mood ___ Mood swings ___ Rapid speech ___ Phobias ___ Sleep disturbances ___ Hallucinations ___ Memory lapses ___ Eating disorder ___
Repetitive thoughts (e.g., Obsessions)___ Repetitive behaviors (e.g., Frequent checking, Hand washing)

List any significant life changes or stressors in the past:

_____

RELIGIOUS/SPIRITUAL ORIENTATION

What is your religious or spiritual orientation?_____

MARITAL RELATIONSHIP HISTORY

Are you currently in a relationship? Y ___ N ___ How long? _____

	Past		Current	
Domestic spousal abuse/violence	Y ___	N ___	Y ___	N ___
Physical abuse	Y ___	N ___	Y ___	N ___
Emotional abuse	Y ___	N ___	Y ___	N ___
Sexual abuse or assault	Y ___	N ___	Y ___	N ___

How satisfying is your relationship? (circle one)

1	2	3	4	5
not satisfying				very satifying

FAMILY MENTAL HEALTH HISTORY:
List members in your family that may have or is experiencing difficulties with the following?

Difficulty	**Family Member**
Depression	_____
Bipolar Disorder	_____
Anxiety Disorders	_____
Panic Attacks	_____
Schizophrenia	_____
Alcohol/Substance Abuse	_____
Eating Disorders	_____
Learning Disabilities	_____
Traumas	_____
Suicide	_____

Educational Background

Highest educational level/training _____

CURRENT FAMILY INCOME (annual):

Below $25,000___ $50,000 - $75,000___ $75,001 - $100,000 ___ $100,000-$150,000 ___ Above $150,000 ___

Lifestyle

Has anyone complained about your drinking/drug use?	Y ___	N ___
Have you ever felt guilty over your drinking/drug use?	Y ___	N ___
Do you typically have a drink to get going in the morning?	Y ___	N ___
Has your alcohol/drug use caused problems at work, home, or personal life?	Y ___	N ___
Have you ever blacked out from alcohol/drug use?	Y ___	N ___
Have you been *charged* with a DUI	Y ___	N ___
Do you smoke cigarettes?	Y ___	N ___

How often do you have 4 or more drinks in a 24-hour period?_____

What do you consider to be your strengths? _____

_____

What are your goals for therapy? _____

_____