# Christy Anderson Jacob, Ph.D

Licensed Psychologist

**INTAKE INFORMATION**

The following information will help me get to know you and the issues important for your therapy. All information will be kept confidential.

Date: _____ Referred by: _____

Name: _____ Phone: Home _____

First M.I. Last Work _____

Cell _____

Address: _____ Email _____

_____ Birthdate _____

Emergency Contact: _____ _____ _____

Name Phone Relationship

Marital Status: S M D W Name of Spouse/Partner: _____ Age: _____

Previous marriages/long-term relationships: _____

_____

Children: Name Date of Birth School/Grade Live with you? Adopted/Step?

_____

_____

_____

_____

With whom do you live? _____

Employer: _____ Type of Work: _____

Present/Past Medical Concerns: _____

Medications: _____

Physician: _____

Insurance Information: Name of Company: _____

Name of Insured: _____

ID #: _____ Group #: _____

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Arden Hill, MN 55112

651-389-4406
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Reason for seeking therapy at this time: _____

_____

Previous therapy (Name of therapist, issues, when, length of treatment): _____

_____

_____

Do you use alcohol or mood altering chemical? What kinds? How often? _____

_____

Please check any of the problems or symptoms below that apply to you:

_____ Child Care
_____ Employment/school problems
_____ Legal problems
_____ Living arrangements
_____ Money management problems
_____ Anxious, worried, nervous
_____ Appetite or weight loss
_____ Confusion
_____ Unexplained crying
_____ Extravagance with money
_____ Fatigue
_____ Forgetfulness
_____ Frequent lying
_____ Generalized dissatisfaction
_____ Guilt feelings
_____ Difficulty being alone
_____ Limiting activities or staying home due to anxiety
_____ Mood swings
_____ Hyperactivity
_____ Panic attacks
_____ Perfectionistic, over-attention to detail.
_____ Shy, uneasy with others
_____ Suicidal thoughts
_____ Trouble sleeping
_____ Other: _____

_____ Unwanted behavior, habits (compulsions)
_____ Withdrawn
_____ Worry about drug or alcohol use
_____ Worry about eating habits
_____ Aggressive/violent behavior
_____ Being physically or sexually abused
_____ Physically abusing spouse/significant other
_____ Physical or sexual abuse of a child
_____ Excessive fighting
_____ Sexual problems
_____ Sexual identity concerns
_____ Headaches or abdominal distress
_____ Menstrual cycle problems
_____ Other physical or medical symptoms
_____ Marital problems
_____ Problems in ongoing nonmarital relationship (romantic or close friend)
_____ Problems related to termination of marital or other close relationship
_____ Problems with family (parent - child)
_____ Other interpersonal problems
_____ Unassertive
_____ Sadness, depression
_____ Trouble with memory or concentration

Family History

Family of Origin: Include yourself and any siblings now deceased, stillbirths, miscarriages.

| Name | Age | Occupation | Chronic Illness | Marital Status | Where do they live |
|---|---|---|---|---|---|
| Father: | | | | | |
| Mother: | | | | | |
| 1st Child: | | | | | |
| 2nd Child: | | | | | |
| 3rd Child: | | | | | |
| 4th Child: | | | | | |
| 5th Child: | | | | | |
| 6th Child: | | | | | |

Has anyone in your family of origin or current family, including yourself, experienced: (Indicate yes or no, and fill in details below.)

_____ Mental health problems
_____ Chemical abuse
_____ Emotional problems
_____ Physical problems
_____ Sexual problems
_____ Suicide attempts
_____ Eating disorders

| Name | Relationship to you | Problem | Treatment rec'd | Still a problem? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please add any other additional information that you feel may be important: (use back if desired)

_____

_____

I understand that it is my obligation to pay for all services provided, including all services not covered by insurance.

_____ _____
Signature Date

_____ _____ _____
Witness (if minor or vulnerable adult) Date Relationship