Sarah Sarkis, Psy.D.,

LICENSED PSYCHOLOGIST

PATIENT INTAKE FORM

- **Please provide the following information for my records.**
- **Leave blank any question you would rather not answer.**
- **Information you provide here is held to the same standards of confidentiality as our therapy.**
- **If any given question does not apply to you, please, put down "n/a" or "none"**

Name:
Birth Date:
Address:
Home Phone/May I leave a message?:
Cell Phone/May I leave a message?:
E-mail:
Age:
Social Security Number (necessary for billing):
Name of your Insurance (from the insurance card):
Insurance ID #:
Gender:
Marital Status:
Number of Children:
Who referred you to this practice?:

Are you currently in treatment with another mental health provider?

Are you currently on any psychotropic medication (e.g. antidepressants, etc.)?

If so, what are you currently taking? (please, list medication name and dose)?

Who is prescribing these medications for you?

If you are not currently on psychotropic medication but you have been, what were you on and who prescribed this for you?

Have you had psychotherapy/counseling before? Who with?

Are you on any medication at all (not just psychiatric)? If so, what and how much (and what is it treating)?

HEALTH/SOCIAL/LEGAL HISTORY

1. How is your physical health?

2. Any chronic physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.)?

3. Any sleep problems? If so, please, describe:

4. Do you have a regular wellness/exercise routine? If so, please, describe:

5. Any problems with appetite or eating? If so, please, describe:

6. Do you regularly use alcohol? Other substances? If so, please, describe (what, how often, how much):

7. Have you ever been arrested/convicted/any D.U.I.s? If so, please, describe:

8. Do you ever thinking about killing yourself? Have you ever attempted to kill yourself? Please, describe:

9. Are you having any relational problems? If so, please, describe:

10. What stresses you out at present/currently? Please, describe:

Have you ever experienced:

Extreme depressed mood	yes/no
Wild Mood Swings	yes/no
Rapid Speech	yes/no
Extreme Anxiety	yes/no
Panic Attacks	yes/no
Phobias	yes/no
Sleep Disturbances	yes/no
Hallucinations	yes/no
Unexplained losses of time	yes/no
Unexplained memory lapses	yes/no
Alcohol/Substance Abuse	yes/no
Frequent Body Complaints	yes/no
Eating Disorder	yes/no
Body Image Problems	yes/no
Repetitive Thoughts (e.g., Obsessions)	yes/no
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	yes/no
Homicidal Thoughts	yes/no
Suicide Attempt	yes/no

HOSPITALIZATION HISTORY:

Have you ever been psychiatrically hospitalized? If so, voluntarily? Involuntarily? When/where? Please, describe:

When did the current symptoms start to surface?

Was there a precipitating event (death, loss, break up, financial issues, etc) or did the symptoms seem to happen without provocation?

PROFESSIONAL/OCCUPATIONAL HISTORY:

What is your education level?

What do you do for living?

FAMILY MENTAL HEALTH HISTORY:

Has any member of your immediate family received any psychiatric/psychological treatment? If so, please, describe (for what problem, what type of treatment)?

OTHER INFORMATION:

What is your first childhood memory? Please provide details? Who, what, when, etc? (write on back if you desire more space)

If you had to describe your mother in one word, what would it be?

And now your father?

How do you feel about yourself?

How do you cope with moderate to severe stress?

How do you respond to grief, loss and/or disappointment?

What do you hope to get from therapy?

What do you read?

What do you watch on TV?

Do you have a meditation practice?

What, if any, is your religious/spiritual background?

DIET/LIFESTYLE/NUTRITION (*please provide as much detail as possible in this section*):
Please provide basic information about your daily diet. Do you have food allergies? If so, what are they? Do you drink caffeine? If so, what type and how much? Do you eat processed foods? If so, provide examples.

Were you breastfed or bottle fed as an infant? *(if you do not know, please indicate that)*

Are you vegetarian? Yes/No
If so, do you take vitamin B 12 supplement?
If yes, what form (oral, iv, sublingual)?

Do you take omega-3 fatty acid supplements? Yes/No
If yes, how much/day?

Do you eat/drink dairy? Yes/No
If yes, how much/day?

Do you eat gluten? Yes/No
If yes, how much/day?

Have you had your thyroid tested in the last 6 months? Yes/No
If yes, please provide me with a copy of those results.

Do you crave sweet or savory food? Savory/sweet/both
Do you feel you have ample restraint to refrain from these cravings or do they feel out of your control?

What was the culture of food in your household growing up?

Do you suffer from eczema, rashes etc?
If so, do you recall the treatment?

Did you suffer from chronic ear infections? Yes/No
If so, do you recall how often you were put on antibiotics?

Did you struggle with attention related issues in elementary school? Or hyperactivity?
If so, how did your school and family help you to manage these symptoms?

Is there anything else you feel I should know related to how nutrition and food impacts your life?