



Anthony O. Wells, Ph.D.
Licensed Clinical Psychologist
 1223 3rd Street, SW
 Roanoke, Virginia 24016
 Phone: (540) 737-8802, Fax: 877-285-0379

INTAKE FORM

Please take a moment before our appointment to complete this questionnaire, Thank you.

The client is a (check one) child adolescent adult Date: _____

Client's Name: _____

If the client is a youth, parent/ guardian's name (s): _____

Client's Address: _____

Home phone: _____ Email: _____

Work: _____ Can you be contacted at work? _____

Client's Employer: _____ Occupation _____

Age: _____ Date of Birth: _____ Social Security# _____

Single _____ Married _____ Separated _____ Divorced _____ Other _____

Spouse/ Partner's name: _____ Age: _____ Occupation _____

Children's names/ ages: _____

Who lives at home with client? _____

Emergency contact: _____ Phone: _____

Client's relationship to emergency contact: _____

Who referred you for therapy or an evaluation? _____

Insurance company: _____ ID#: _____

Have you obtained authorization for today's visit? _____ **Please let me copy your ID card.**

Name/ SS# of person responsible for payment: _____

What is the highest school grade client completed? _____

Is client in school now? _____ Which school? _____

What are (were) client's grades/ attendance like? _____

Client's health concerns? (please explain): _____

When did client last see a physician (Name)? _____

Client's current medications? _____

Reasons for seeking help at this time: _____

How have you tried to deal with this? _____

Have you seen a mental health professional before? (please explain): _____

What do you expect or hope to happen with therapy or evaluation? _____

Circle any of the following which you have experienced *within the last year*:

- | | | | |
|-----------------------|---------------------|-------------------|---------------------|
| Nervousness | Depression | Eat too much | Legal troubles |
| Trouble concentrating | Sadness | Don't eat well | Money troubles |
| Trouble remembering | Shyness | Sleep too much | School troubles |
| Low energy | Low self-esteem | Can't sleep well | Job troubles |
| Unable to relax | Feeling hopeless | Headaches | Retirement |
| Obsessive thoughts | Feeling guilty | Back troubles | Recent move |
| Racing thoughts | Anger problems | Drug use/abuse | Isolated |
| Nightmares | Suicide attempt | Alcohol use/abuse | Lonely |
| Feeling afraid | Relationship issues | Sexual Issues | Out -of-control |
| Seeing unreal things | Impulsiveness | Medical problems | Stressed out |
| Feeling pressured | Self-critical | Weight problems | Loss of a loved one |
| Hearing voices | Must be perfect | Parent troubles | Crying a lot |

Other _____

(Now please place an x next to any of those that you are currently experiencing)

Violent thoughts (please describe) _____

Suicidal thoughts (please describe) _____

Religious/ Cultural background: _____

What are some things about yourself and your life that are going well for you? _____

Who is most supportive of you? _____

What are your hobbies/ interests? _____

What other information do you feel is important for me to know _____

Thank you for providing this information. I look forward to meeting with you shortly.

Please feel free to discuss with me any questions or concerns at any time.