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 your shortly.

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