**Donna M. Martin, Psy.D.**

334 W. Broad Street

Quakertown, PA 18951

**Client Information/Adult Intake and Assessment**

Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identification:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Home street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home/Evening phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best number to reach you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave our name when calling or e-mailing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Dr. Donna Martin Psy. D.?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give us permission to thank this person for the referral? ❑ Yes ❑ No

**Religious and racial/ethnic identification:**

Religious affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu ❑ Other

Involvement: ❑ None ❑ Some/irregular ❑ Active

Ethnicity/national origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sexual Orientation:** ❑Heterosexual❑Bisexual❑Gay/Lesbian❑Questioning

**Relationship Status:** ❑Single❑In a Relationship❑Married❑Separated❑Divorced❑Widowed

**Legal History:**

1. Are you presently suing anyone or thinking of suing anyone? ❑ Yes ❑ No

2. Is the reason for coming to see me related to an accident or injury❑ Yes ❑ No

3. Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ Yes ❑ No

4. Are you in any other legal pending involvements? (i.e. Custody, DUI, Personal Injury) ❑ Yes ❑ No

**Your Current Employer:**

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calls will be discreet, but please indicate any restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you ever in the military? ❑ Yes ❑ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Education/Last School Attended:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dates  To-----From | School | Field Of Study | Adjustment To School | Graduated Or Years Completed |
|  |  |  |  |  |

**Family Information:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relative | Name | Current Age Or Age At Death | Health Issues Or Other Concerns | Their Education | Their Occupation |
| Father |  |  |  |  |  |
| Mother |  |  |  |  |  |
| Brother |  |  |  |  |  |
| Brother |  |  |  |  |  |
| Sister |  |  |  |  |  |
| Sister |  |  |  |  |  |
| Others |  |  |  |  |  |

1. Describe what it was like growing up in your family of origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Is there a history of mental health or drug and alcohol problems in your family: ❑ Yes ❑ No

Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Relationships:**

**Children:**

List all your children:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | Age | Sex | School Aged Child | Living At Home | Grade | Adjustment Problems |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Household Members**:

List all other current members in your household:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | Age | Sex |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Are you having problems with your present spouse or partner? ❑ Yes ❑ No

2. Are you having problems with your children? ❑ Yes ❑ No

3. Are you having problems in your relationships with your friends? ❑ Yes ❑ No

4. Are you having problems at your present place of employment? ❑ Yes ❑ No

**Health Habits:**

1. Do you regularly engage in physical exercise? ❑ Yes ❑ No

2. Do you try to restrict your eating in any way? ❑ Yes ❑ No

3. Do you have any concerns about your eating habits? ❑ Yes ❑ No

4. Are you having problems sleeping? ❑ Yes ❑ No

5. Do you gamble? ❑ Yes ❑ No

**Brief Health History:**

1. Starting with your childhood and preceding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

(List pregnancies in other section provided on Page 8)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age | Illness/Diagnosis | Treatment Received | Treated By | Result |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

2. List and describe any allergies (drug and other) you have.

|  |  |
| --- | --- |
| Allergies | Reactions |
|  |  |
|  |  |
|  |  |

3. List *all* medications, drugs, or other substances you take or have taken in the last year—prescribed, over-the-counter medications, vitamins, herbs, and others.

(Provide separate page if needed)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication/Drug | Dose | Reason For Taking | Prescribed By |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

4. Have you ever been exposed to toxic chemicals? ❑ Yes ❑ No

5. Date of last physical \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was blood work done? ❑ Yes ❑ No

**Mental Health Treatment History:**

Have you ever been hospitalized for a mental health problem ❑ Yes ❑ No

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Hospital | Reason | Results |
|  |  |  |  |

Have you ever or are you receiving mental health, drug or alcohol treatment? ❑ Yes ❑ No If yes, list ALL

|  |  |  |  |
| --- | --- | --- | --- |
| Date | From Whom | For What | Results |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever or are you presently taking psychiatric medications? ❑ Yes ❑ No If yes, please list ALL

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Medications | Dosage | Prescribed By | For | Still Taking |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Screenings/Assessments:**

**Abuse History:**

❑ I was not abused in any way. ❑ I was abused.

If you were abused, please circle any of the following types of abuse that applies and this will be discussed upon intake.

**P** = Physical, such as beatings. **S** = Sexual, such as touching/molesting, fondling, or intercourse.

**N** = Neglect, such as failure to feed, shelter, or protect. **E** = Emotional, such as humiliation, etc.

**Symptoms (In the past 30 Days)**

**Circle any Incidence of:**

|  |  |
| --- | --- |
| 1. Sad, depressed mood | 1. Crying frequently |
| 1. Diminished interest in pleasure | 1. Insomnia or sleeping too much |
| 1. Change in eating pattern | 1. Diminished capacity to concentrate |
| 1. Feeling of guilt or worthlessness | 1. Feeling of helplessness or hopelessness |
| 1. Thoughts of death or suicide | 1. Thoughts of homicide |
| 1. Lack of energy |  |

Mood swings: Alternating depression "sad" and euphoric "manic" ❑Yes❑No

Elevated mood: Highly talkative, flight of ideas, agitated ❑Yes❑No

Panic attacks: Intense fear or discomfort, racing heart, trembling for no reason ❑Yes❑No

Anxiety/Phobia that is excessive: it may include excessive worrying. ❑Yes ❑No

Verbal Anger/Rage ❑Yes ❑No

Explosive outbursts or acting violently ❑Yes❑No

Compulsive behaviors ❑Yes❑No

Intrusive thoughts ❑Yes❑No

Problems with attention and focus ❑Yes❑No

Problems completing tasks ❑Yes❑No

Frequently losing or misplacing things ❑Yes❑No

Interrupting others in conversation ❑Yes❑No

Following rules ❑Yes❑No

History of suicide attempts ❑Yes❑No

History of any other self-harming behaviors (i.e.cutting) ❑Yes ❑No

Are there weapons in your home? ❑Yes ❑No

Hair Pulling/Skin picking ❑Yes ❑No

**Drug/Alcohol Use:**

**Alcohol use**:

1. How many alcoholic drinks do you have in a typical week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you feel you are a “normal” drinker? ❑ Yes ❑ No

(“normal” = drink as much or less than other people )

**Drug use**:

1. Do you believe you have a drug problem? ❑ Yes ❑ No

2. List all illegal drugs or medications not prescribed for you that you have used in the last month? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. List all illegal drugs or medications not prescribed for you that you have used in your lifetime?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you ever used inhalants (“huffing”), such as glue, gasoline, or paint thinner? ❑ Yes ❑ No

**Physical Health Concerns:**

1. How many cups of regular coffee do you drink each day? \_\_\_\_\_ How many cups of tea? \_\_\_\_\_\_\_\_ How many sodas with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? \_\_\_\_\_\_\_\_ How many “energy drinks”? \_\_\_\_\_\_\_\_ How often do you use No Doz or similar caffeine pills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you a nicotine user? ❑ Yes ❑ No If yes, what form and how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Woman’s Health:**

1. What age did you start to menstruate (get your period): \_\_\_\_\_\_\_

2. Menstrual period experiences:

a. How regular are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_b. How long do they last?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. How much pain do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ d. How heavy are your periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Other experiences during periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Please list all of your pregnancies:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Your Age | Child Born | Miscarriage | Abortion | Problems |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |

4. **Menopause**:

a. If your menopause has started, at what age did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. What signs or symptoms have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chief Concern/Problem:**

Please state the main difficulty that has brought you to see me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe anything else that is important for me to know.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_