Sherrie Campbell Ph.D.

PSY 20227
4811 Eureka Ave, Suite G1
Yorba Linda, CA 92886
714-779-9029

Intake Form

Date _____

Last Name _____ First Name _____
Address _____
City _____ State _____ Zip _____
Sex (M/F) _____ Birth Date _____ Referred By _____

May I contact you by email for scheduling purposes? _____ Email Address: _____

Home Phone _____ Can I call you here? _____ Can I leave a message? _____
Cell Phone _____ Can I call you here? _____ Can I leave a message? _____

Briefly tell me about the issues/concerns that have brought you here.

_____
_____
_____
_____
_____
_____
_____
_____

Please check any current or past issues that still affect you.

____ Eating Disorder
____ Academic/Work Issues
____ Childhood Abuse (i.e. physical, sexual, emotional)
____ Stress/Anxiety
____ Phobias (type: _____)
____ Family Issues (i.e. divorce, alcoholism, domestic violence)
____ Alcohol/ Drug Use
____ Sexual Assault/Rape
  ____ recently (when: _____)
  ____ in the past
____ Death of Someone Close
  ____ recently (when: _____)
  ____ in the past
____ Other: _____

____ Pregnancy Issues
____ Spiritual Concerns
____ Depression
____ Pornography
____ Sexual Identity Issues
____ Suicidal Thoughts
____ Relationship Concerns
  ____ family
  ____ friend
  ____ parent
  ____ significant other
  ____ roommate
  ____ other: _____

_____

Current medical problems _____
Current medications *(all, including herbal)* _____
Are you currently working with a Personal Physician? _____ Phone Number: _____
Name _____What for? _____
Have you been on any medications in the past for mental health issues? _____
(Please list) _____

Have you previously seen a therapist? _____ Who/Where? _____
How long ago? _____ For what types of issues? _____
Are you currently seeing a therapist? _____
Have you ever been hospitalized for physical or mental health issues? *(Briefly describe)*_____
_____
Have you had any previous suicide attempts? _____*(Briefly describe)*_____
_____

If you are currently experiencing any of the following symptoms, please rate them using the number key below.

Never = 0	*Seldom =1*	*Often = 2*	*Always = 3*

_____ Difficulty concentrating
_____ Crying
_____ Missing classes/work
_____ Feeling helpless
_____ Feeling uptight
_____ Worrying
_____ Feeling hopeless
_____ Feeling afraid
_____ Lying to others
_____ Feeling out of control
_____ Feelings of self-doubt
_____ Injuring self
_____ Nervous around others
_____ Suicidal thoughts
_____ Memory loss or blackout
_____ Difficulty sleeping
_____ Stealing
_____ Anger
_____ Eating binges
_____ Drinking heavily
_____ Drug use
_____ Feeling guilty
_____ Withdrawing socially
_____ Sexual preoccupation
_____ Physical symptoms *(i.e. headaches, digestive)*
List: _____
Have you seen a health care provider for these? _____
Other: _____

Please use the scale below to answer the following questions.

4=True to a great extent ***3=Mostly true*** ***2=Somewhat true*** ***1=Not at all true***

My current concerns affect my success in life. _____

My current concerns affect my ability to interact and connect with others. _____

I am optimistic that I will be able to make some positive changes as a result of counseling. _____

_____