Dr. Sherrie Campbell
love yourself & life will shift

(714) 779-9029 • drsherrie@drsherriecampbell.com • drsherriecampbell.com

INTAKE FORM

Full Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ Birth Date: _____

Referred By: _____

Email Address: _____

May I contact you by email for scheduling purposes? ☐ Yes ☐ No

Home Phone Number: _____

Can I call your home phone (Yes/No)? _____ Can I leave a message (Yes/No)? _____

Cell Phone Number: _____

Can I call your cell phone (Yes/No)? _____ Can I leave a message (Yes/No)? _____

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

Current medical problems: _____

Current medications (all, including herbal): _____

Are you currently working with a Personal Physician? ☐ Yes ☐ No

If Yes, Physician's Name: _____ Phone Number: _____

What are you seeing the physician for? _____

Have you ever been on medications for mental health issues? ☐ Yes ☐ No

If yes, please list: _____

Have you previously seen a therapist? ☐ Yes ☐ No

If yes, who and where? _____

How long ago? _____ For what types of issues? _____

Are you currently seeing a therapist? ☐ Yes ☐ No

If yes, who and where? _____

Have you ever been hospitalized for physical/mental health issues? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, please 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

____ Memory loss or blackout

____ Difficulty sleeping

____ Stealing

____ Anger

____ Eating binges

____ Worrying
____ Feeling hopeless
____ Feeling afraid
____ Lying to others
____ Feeling out of control
____ Feelings of self-doubt
____ Injuring self
____ Nervous around others
____ Suicidal thoughts
____ Other: _____

____ 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? ____

Please use the scale below to rate the following statements.

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 counseling will help me make some positive changes: _____

Your signature below indicates that you have received and completed this Intake Form and that the information above is accurate.

_____ _____
Client Signature Date

_____
Client Name (Print)