ELLEN A. SHERMAN, Ph.D.

INTAKE FORM

Today's Date _____
Note: If you are a returning patient, please fill in only the information that has changed.
Name _____

Birth Date _____

Home Address _____

City _____**State**_____**Zip Code**_____

Home Phone _____ **Cell**_____**Work** _____
E-Mail_____

Check where I can call you or leave a message? Home _____**Cell**_____
Work_____**E-Mail**_____

Referral Source _____**Phone**_____
May I have your permission to thank this person for the referral? Yes _____**No**_____

Primary Care Physician's Name _____
May I consult with your medical doctor so that he/she is fully informed and we can coordinate treatment? Yes ____ **No** ____

Have you ever received psychological, psychiatric, drug or alcohol treatment or counseling services? Yes ____ **No**____ **Please circle which type of treatment you sought.**

Have you ever taken medication for psychiatric or emotional problems? Yes____ **No**____
Please list medication you are taking or have taken. _____
_____
_____

Do you have any chronic or crucial health issues? Yes ___ **No**___ **Please list these health issues.**
_____
_____

Do you use alcohol or drugs daily? Yes ____ **No**____
Has anyone criticized your alcohol or drug use? Yes___ **No**___
Do you smoke or chew tobacco? Yes ____ **No**____
Which drugs (not medications) have you used in the last 10 years? _____
_____

THIS IS A STRICTLY CONFIDENTIAL PATIENT MEDICAL RECORD