New Patient Intake Form
Please download, complete and email to DrRon@RonaldAlexander.com
or bring with you to your first appointment

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(310) 395-2243 (Please note: This is a landline - no text messages)
www.RonaldAlexander.com

Name:____

Address:____

If Married/Civil Union, Partner's Name: ___________________________
Yrs. Married: _________

If Not Married (Circle One): Separated, Widowed, Divorced, Single Committed Relationship

Prior Marriages: from _____ to _______ Name: __________________

From ______ to ________ Name: _________________

Children:	Name	Age	Name of other Parent
	_____________________	_______	_________________
	_____________________	_______	_________________
	_____________________	_______	_________________

Where were you born? ____

Education: Highest grade completed or Degree _________________________

Previous therapy:

Year	Length	Therapist's Name	City	Problem
______	_______	____________________	________	___________
______	_______	____________________	________	___________
______	_______	____________________	________	___________

Have you ever been hospitalized for psychiatric reasons if yes where, when and how long?

Religious Upbringing:
Religious Group: ___________________________ Conservative or Reform (Circle One)

Currently Practicing: ________________________ Location: __________________

In case of emergency, please notify: _____________________________________

Address: ____

Phone: ____

Relation to you: ____

Reason for Consultation (Please describe in your own words):

Why are you seeking support at this particular time?

Recent Stresses (Please check if you have experienced any of the following in the past months):

______ Marriage or divorce of yourself or someone you are close to
______ Victim of physical or sexual assault
______ Moved to a new location
______ Financial crisis
______ Death of a relative or close friend
______ Arrested by law enforcement
______ Lost job; new job
______ Child moving from home or other parenting problems
______ Drug/alcohol
______ Serious decline in your health or someone close to you
______ Major accident or physical condition
______ Eating disorder
______ Harm towards others
______ Self harm
______ Sleep disorder
______ Sexual problems

Please describe your current medical condition: ______________________________

Current Medications:
<u>Name of Drug</u> <u>Dosage</u> <u>Purpose</u>

___________________________ _______ _________________________

__________________________ _______ ________________________

__________________________ _______ _________________________

Are you under the current care of a Psychiatrist or Medical Doctor for these medicines? If so name, address and phone number of the Doctor.

May I have your permission to contact and consult with your Doctor? YES ____ NO ____

If in physical pain, please explain:

Family Health History (Immediate and other relatives):

	Who	Relationship to You
___Alcoholism	________________________	_______________________________
___Drug Addictions	________________________	_______________________________
___Anxiety	________________________	_______________________________
_____Suicide	________________________	_______________________________
___Hospitalizations (Mental)	________________________	_______________________________
___Chronic Physical Conditions	________________________	_______________________________
___ Physical or Emotional Abuse	________________________	_______________________________

How many hours do you sleep per night? ____________________________

How is the quality or your sleep? _____________________________________

Do you have nightmares or recurrent dreams? (Please describe)

Are you now, or have you ever, experienced any of the following symptoms:

_____Sad _____Insomnia _____Lost interest/Friends

_____Crying Spells _____ Waking Early _____Lost interest/Sex
_____Appetite Loss _____Excessive Sleep _____Easily Fatigued
_____Weight Loss _____Feeling Hopeless _____Suicidal thoughts

_____Nervous/Jittery _____Low Concentration _____Heart Palpitations
_____Mood Swings _____Tension _____Temper Outbursts
_____Irritability _____Worrying _____Persistent Thoughts
_____Fatigue _____ Sweating _____Memory Loss
_____Headaches _____ Confusion _____Stomach Problems
_____Vomiting _____Weight Loss _____Out of Body Exp.
_____Change in Taste _____ Visual Auras _____ See Spots/Lights
_____ Personality Change _____ Seizures _____ Hot/Cold Spells
_____ Alcohol Use _____ Marijuana Use _____ Cocaine Use
_____ Stimulant Use _____ Hallucinogen Use _____ Other
_____ Non-prescription Narcotic _____ Non-prescription Tranquilizer

Have you ever experienced any violent or aggressive behavior towards self or others? Are you currently feeling suicidal? __________________________

Have you felt suicidal or attempted suicide in the past? (Explain circumstances)

Have you ever experienced or suffered from any form of abuse. If so please explain in detail?

Have you ever received any treatment that included Hypnosis, Guided Imagery or EMDR or other system of psychotherapy for the specific treatment of abuse, trauma, and psychological or medical conditions?

Have you ever been involved in litigation or made a complaint to any State Medical or Psychological Board or the Board of Behavioral Sciences or are you currently involved in any litigation or complaints against any health professional or medical practitioner? If so please explain.

Have you ever or do you currently use recreational drugs. If yes what kinds and how often?

What are you current skills, strengths, interests and joys in your personal and professional life? Where do you feel that you are thriving, winning or growing?

Client Name Printed	Date	Client Signature

____

Parent Name Printed (If Client is a Minor)	Date	Parent Signature

Ronald A. Alexander Ph.D.	Date