

Intake Form

Instructions: Your personal information and signed consent to begin therapy is required and it is important to have this information on file. Please download this form, fill out the necessary information, sign, scan and e-mail to drjfine@gmail.com or Fax to Dr. Jeffrey Fine at +972-4-811-2778 From America 011-972-4-811-2778 24 hrs prior to beginning any therapy.

If you need more space to write your information, use an additional blank page with this form.

Name _____ Age _____ Birth date _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone: _____

Occupation _____ Employer _____

Marital Status _____ Name of Spouse/Partner _____

How Long Have Both of You Been Together? _____ Religion _____

If Client is a Minor, We only treat minors in group family counseling.

Describe minor _____

Name of Closest Friend/Relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

There are times when prior medical and psychological records will be requested.

Please make sure that all information given below is correct

All of this information is strictly confidential.

Do You Smoke? _____ How Much? _____ Do You Drink? _____ How Much? _____

Do You Take Drugs? _____ If yes, what kind? _____ How often? _____

Last Medical Examination _____ Reason _____

Are You Now Under a Doctor's Care? _____ If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication? _____ If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? Describe: _____

Have you ever been hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc? Describe:

Any Previous Therapy/Counseling? _____ If Yes, Name and Phone Numbers of Therapists: _____

When and Number of Sessions: _____

Type of Therapy/Counseling: _____

What do you wish to Achieve with Therapy? _____

Check Any of the Following That May Apply to You:

<input type="checkbox"/> Headache	<input type="checkbox"/> Inferiority Feelings	<input type="checkbox"/> Shy With People
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Feel Tense	<input type="checkbox"/> Can't Make Friends
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Feel Panicky	<input type="checkbox"/> Afraid Of People
<input type="checkbox"/> No Appetite	<input type="checkbox"/> Fears and Phobias	<input type="checkbox"/> Home Conditions Bad
<input type="checkbox"/> Over-Eating	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Unable To Have A Good Time
<input type="checkbox"/> Stomach Trouble	<input type="checkbox"/> Depressed	<input type="checkbox"/> Always Worried About Something
<input type="checkbox"/> Bowel Disturbances	<input type="checkbox"/> Suicidal Ideas	<input type="checkbox"/> Don't Like Weekends/Vacations
<input type="checkbox"/> Always Tired	<input type="checkbox"/> Take Tranquilizers	<input type="checkbox"/> Can't Make Decisions
<input type="checkbox"/> Always Sleepy	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Over-Ambitious
<input type="checkbox"/> Unable To Relax	<input type="checkbox"/> Dangerous Drugs	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Allergy	<input type="checkbox"/> Gambling
<input type="checkbox"/> Recurrent Dreams	<input type="checkbox"/> Asthma	<input type="checkbox"/> Job Problems
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Homosexuality	<input type="checkbox"/> Can't Keep A Job
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Sexual Problems	<input type="checkbox"/> Other

Upon my signature below, I hereby attest that all the information furnished is true and correct.

Signed

Date