

Jeffrey Chernin, Ph.D., MFT
6310 San Vicente Blvd. Suite 410
Los Angeles, CA 90048
(323) 692-7781

Confidential Intake form

Name _____

Address _____

City _____ State/Zip _____

Birth date _____

Home phone _____

Cell phone _____

Place of employment and position _____

Work phone _____

Spouse/partner's name _____

In case of emergency, contact:

Name: _____ Phone _____

Please note that if you would like to be reimbursed by your insurance company, I will give you a form to send to your insurance company on a monthly basis. In order to complete the form, please fill out the following information.

Insurance Company _____ Phone # _____

Subscriber ID# _____ Group # _____

Do you have additional insurance (yes/no)? _____

Why are you seeking counseling at this time? Please include current sources of stress:

MARK THE BOX TO THE LEFT FOR ITEMS THAT ARE TROUBLING YOU

- | | | | |
|--|--|---------------------------------------|--|
| <input type="checkbox"/> Co-workers | <input type="checkbox"/> Family members | <input type="checkbox"/> Friends | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Eating/food | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Anger outbursts | <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Self-harm | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Gambling | <input type="checkbox"/> Internet use | <input type="checkbox"/> Sexual activities |
| <input type="checkbox"/> Legal matters | <input type="checkbox"/> Debt/spending | <input type="checkbox"/> Career/work | <input type="checkbox"/> Isolation |

Are you taking any medications (yes/no)? ____

If yes, please list:

Medication	Dosage	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a Primary Care Physician (PCP)? (yes/no) _____

If yes, PCP Name: _____ Phone number: _____

Have you had any previous psychotherapy, psychiatric care, or hospitalization for a mental disorder, or drug/alcohol problem? (yes/no) _____

Please provide the approximate dates and reasons you sought assistance:
