

Aimee G. Jordan, Psy.D.

*Clinical Psychologist
(650) 847-0185
PSY 26253*

*1670 S. Amphlett Blvd., Suite 214
San Mateo, CA 94402*

Intake Form

NAME: _____ DATE: _____

ADDRESS: _____

TELEPHONE: _____ D.O.B.: _____

REFERRAL BY: _____

EMERGENCY CONTACT/NUMBER:

MARITAL STATUS: _____

SPOUSE NAME: _____ CHILDREN/STEP/GRAND (names/ages):

SIBLINGS (names/ages):

PARENTS/STEPPARENT(s) (Ages or year of death):

OCCUPATION/POSITION:

PRESENTING PROBLEM:

MEDICAL DOCTOR(S): _____ PHONE(S): _____

LAST EXAM: _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations, current medication):

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: _____ Dates: _____ to _____

Initial reason:

Process and outcome:

2. Therapist: _____ Dates: _____ to _____

Initial reason:

Process and outcome:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

Use the space at bottom of this form if you need to give further information.