

Intake Formular Psychotherapy

Date: _____

First and last name: _____

Gender: m f d

Date of birth: _____ Age: _____

Address: _____

Street: _____ Postcode: _____

Telephone number: _____ Is it okay to contact you? Yes No

E-Mail: _____ Is it okay to contact you? Yes No

(for e-mail, please sign the consent form last page)

How did you learn about our practice? _____

The reason why you want to attend therapy? Please briefly describe the problems you have.

What do you hope to achieve through the treatment? What are your therapy goals?

How do you deal with stressors and manage the problems you describe?

Are you currently in therapy? Yes No

If yes, when, with whom and for how long? _____

Have you ever been in inpatient psychiatric treatment? Yes No

Are you currently unable to work due to your condition? Yes No

If yes, since when? _____

Which symptoms/problem areas currently apply to you?

- Abuse/trauma - physical, sexual, emotional, neglect
- Aggression, violence
- Alcohol consumption
- Anger, hostility, arguments, irritability
- Anxiousness, nervousness
- Attention, concentration, distractibility
- Professional worries, goals, and decisions
- Problems in childhood
- Co-dependency
- Confusion
- Compulsions and/or obsessions (thoughts or actions that repeat themselves)
- Decision-making, indecision, mixed feelings, postponing decisions.
- Dependence / addiction
- Depression, low mood, sadness, crying
- Divorce, separation, marital conflicts, infidelity/affair
- Drug use - prescription drugs, over-the-counter drugs, street drugs
- Eating problems - overeating, malnutrition, appetite, vomiting
- Emptiness
- Failure
- Exhaustion, tiredness, low energy
- Fears, phobias
- Financial or financial problems, debts, impulsive spending, low income
- Gambling
- Grief, deaths, losses, divorce
- Feelings of guilt
- Headaches, other types of pain
- Health, illness, medical concerns, physical problems
- Feelings of inferiority
- Impulsiveness, loss of control, outbursts of anger
- Irresponsibility
- Difficulty in making judgments, willingness to take risks
- Legal matters, accusations, lawsuits
- Loneliness
- Memory problems
- Mood swings
- Hypersensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, lack of motivation
- Relationship problems (with friends, relatives, or at work)
- School problems
- Self-esteem problems
- Self-neglect, poor self-care
- Sexual problems, dysfunctions, conflicts, identity problems
- Sleep problems (too much, too little, insomnia, nightmares)
- Spiritual, religious, moral, and ethical issues
- Stress and tension
- Mistrust
- Suicidal thoughts
- Irrascibility, self-control, low frustration tolerance
- Mental disorganization and confusion
- Threats, violence
- Weight and diet problems
- Withdrawal, isolation
- Work problems, employment problems, bullying

Please send this intake form via mail to New Leaves Gemeinschaftspraxis, Dr. med. univ. Stefan Schmidinger, Zeltweg 25, 8032 Zurich or email to drschmidinger@hin.ch (HIN-encrypted email transmission for data protection).

Declaration of consent for communication via e-mail: The person listed above approves to communicate via e-mail. I am aware of the risks associated with sending unencrypted e-mails - particularly unauthorized access and use - and I accept these risks.

Yes

Date: _____

No

Your Signature: _____