DR. WILLIAM BIXLER
CENTER FOR EMOTIONAL & SEXUAL HEALTH
140 IOWA LANE, SUITE 201
CARY, NC 27511
919-466-0770

CLIENT INTAKE FORM

Date_____/_____/_____ Referred by_____

Name _____

Birth Date_____/_____/_____ Age _____ Gender M F

Marital Status: Single___ Married___ Divorced___ Separated___ Cohabitating ___

Address_____ City_____ Zip_____

Phone: Home_____ Cell_____ Work_____

Email address _____ Education_____

Occupation_____ Employer_____

Spouse's Name_____ Birth Date _____/_____/_____

Spouse's Employer_____

Names and ages of children_____

Marital History:

1st—Spouse's Name_____ Marriage Date_____/_____/_____

Divorce Date_____/_____/_____

2nd—Spouse's Name_____ Marriage Date_____/_____/_____

Divorce Date_____/_____/_____

3rd—Spouse's Name_____ Marriage Date_____/_____/_____

Divorce Date_____/_____/_____

Physician's Name_____ Phone_____

Psychiatrist's Name_____ Phone_____

Substance Use (Current or Past)_____

Frequency & amount used_____

Current Medical/Physical Problems & Symptoms_____

_____

Current Medications & Dosages_____

Previous Mental Health Treatment (Including any hospitalizations):

Therapist's Names(s)_____

Dates of Service_____

Reasons for Seeking Previous Treatment_____

Family History of Mental/Emotional Illness:_____

_____

Spiritual & Other Support Systems: Support Groups _____

Church/ house of worship_____ Clergy Name_____

How important is religious faith/spirituality in your life? Not very___ Somewhat___Very____

<u>Please check any symptoms which currently apply to you</u>:

Headaches___
Impulsive behavior___
Compulsions___
Financial worries___
Trembling___
Panic, phobias___
Sadness, depression___
Restlessness___
Eating concerns___
Memory problems___
Obsessive thoughts___
Ideas of harming yourself___
Hallucinations___
Stomach problems___
Trouble concentrating___
Grief or loss___
Feelings of hopelessness/
worthlessness___

Aggression/ anger___
Anxiety___
Sexual issues___
Thoughts of harming others___
Isolating yourself___
Excess fatigue___

Disturbing thoughts___
Suicidal thoughts___
Distractibility___
Hyperactive thoughts/behavior___
Chronic worry___

Briefly describe reasons for seeking services:_____

_____

Is there anything we did not ask that you feel is important to share?_____

_____