Kim Loewen, Psy.D.

Clinical Psychologist PSY23978
3990 Old Town Ave, Ste A208 ~ San Diego, CA 92110
Phone: 619.794.4229 ~ Email: kcloewen@gmail.com

NEW PATIENT INFORMATION

Date_____
Patient Name_____ Sex _____ Age_____ DOB ___/___/___
Address_____
City_____ State ____ Zip _____
Phone #_____ Email _____

Emergency Contact: _____
Relationship to patient: _____
Phone #(s)_____
How did you hear about my practice? _____

RESPONSIBLE PARTY FOR BILL (if other than patient):
Name_____ Relationship to patient _____
Address_____
City _____ State_____ Zip_____
Home phone # _____ Work phone #_____

If using Insurance…

INSURANCE INFORMATION:
Company_____
Phone # _____
Name on insurance card _____
Social Security #: _____
Insured's Relationship to Patient: Self ( ) Spouse ( ) Child ( ) Other ( )
Insured ID# _____
Group or Plan # _____
Effective Date of Insurance _____
Authorization (for Medi-Cal)_____

If Not Using Insurance…

By signing below, I agree to pay a fee of $____ per hour to Kim Loewen, Psy.D. for services provided. I understand that this fee is subject to change, and that any change in fee will be as mutually agreed upon. I understand that my fee is subject to periodic review, particularly if my financial situation changes and I am paying a reduced fee. I agree to pay for services at the time they are provided, or as frequently as mutually agreed upon. If I am utilizing my health insurance to pay for these services, I hereby assign any payments from my health insurance provider to Kim Loewen, Psy.D., and I authorize release of information necessary to process a claim with my insurance company. I hereby accept responsibility for any charges not covered by my insurance, and for missed appointments or cancellations with less than 24 hour notice.

Signature _____ Date _____
(If a minor, parent or guardian must also sign.)

Signature _____ Date _____

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INTAKE QUESTIONAIRRE

SOCIOCULTURAL BACKGROUND:

Racial/Ethnic Background (i.e. Asian-American, Latino/a, White, etc)
Please specify how you identify yourself:_____

How much do you identify with your ethnic heritage?
Not at all A little Somewhat Moderately Strongly

Do you identify yourself in other ways that are meaningful to you (e.g., cultural background, sexual orientation, class status, physical ability)**? Please describe:**
_____

Religious preference: _____
Are your currently active in your religion? Yes Somewhat No

ACADEMIC/ WORK BACKGROUND:

Place of employment: _____
Hours worked per week: _____ **Years with employer:** _____
Position: _____

Are you satisfied with your job? Yes No I Don't Know

Highest Educational Degree: _____
Major: _____
Are you a student? Yes No
If yes, where? _____
What are you studying? _____

FAMILY BACKGROUND:

Please list the members of your family, their sex, occupation, and age (e.g. Joseph, father, M, Lawyer, 52; Yolanda, sister, F, teacher 25):

Family Member Name Relationship Sex Occupation Age
_____
_____
_____
_____
_____
_____

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Who currently lives with you? _____

How much conflict do you currently experience with your family (circle one)?
Very little or none Some Moderate Strong Extreme

Who in your family do you currently feel closest to? _____
Most distant from? _____
In most conflict with? _____

SUPPORT SYSTEM:

Please indicate your current relationship status (circle one):
Single In a Committed Relationship Living with Partner Married Separated Divorced Widowed
Other:_____

Approximately how many significant romantic relationships have you had? _____
If you are in a romantic relationship, how long have you been in this relationship? _____
Are you satisfied with your current romantic relationship (circle one)? Yes No I Don't Know
Do you feel supported by your partner/spouse (circle one)? Yes No I Don't Know

How would you rate the quality of your friendships (circle one)?
Very Poor Unsatisfactory About Average Good Excellent

Besides family, who else do you count on for support? _____

PHYSICAL HEALTH:

How is your physical health at present (circle one)?
Poor Unsatisfactory Satisfactory Good Very good

When was your last physical examination? _____
Name and phone number of your primary care physician:
_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):
_____
_____
_____

Do you have a disability (circle one)? No Yes

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If yes, please specify _____

Please list all medications, the reason for which each is prescribed, name of prescribing physician (ie. Lipitor/ high cholesterol/Dr. Joseph):

Name of Medication **Reason Prescribed** **Prescribing Physician**

_____
_____
_____
_____

Are you having any problems with your sleep habits? Yes No
Are you having any difficulty with appetite or eating habits? Yes No
Have you had a significant weight change in the last 2 months? Yes No
Do you have any problems or worries about sexual functioning? Yes No

How many times per week do you exercise? _____ **For how long each time?** _____

MENTAL HEALTH HISTORY:

Have you ever been a victim of: *(if you do not feel comfortable completing this section, simply leave it blank or write "prefer to discuss in person")*

Emotional abuse as a child	Yes	No
Physical abuse as a child	Yes	No
Sexual molestation/abuse as a child	Yes	No
Emotional abuse by a partner/spouse	Yes	No
Physical abuse/assault by a partner/spouse	Yes	No
Sexual abuse/assault as an adult Other Trauma	Yes	No

Specify:_____

To your knowledge, was this abuse reported (i.e. to police or CPS)? Yes No

Have you received counseling here or elsewhere before? Yes No
If yes, where: _____ **When:** _____ **Duration:** _____
What was the focus of previous counseling? _____

Are you currently seeing a psychiatrist or have you seen a psychiatrist in that past? Yes No
If yes, Who: _____ **When:** _____
What psychiatric medications do you take and for what reason?

_____

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How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never
How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never
If so, when: _____
Have you ever attempted suicide? Yes No
If so, when: _____

Have you ever been hospitalized for psychological reasons? Yes No
If so, when: _____

Have you ever intentionally inflicted any harm upon yourself? Yes No
If so, how and when: _____

Are you having thoughts of harming others presently? Frequently Sometimes Rarely Never
How often have you had thoughts of harming others in the past? Frequently Sometimes Rarely Never
If so, when: _____

ALCOHOL AND DRUG USE:

How often do you drink alcohol?
Daily 3+ times per week 1-2 times per week 1-2 times per month Less than once per month Never

How much do you drink? (i.e. # beers/wine/shots per day) _____

In a typical week, on how many days do you have 4 or more drinks? _____

How often do you use other drugs (marijuana, cocaine, ecstasy, meth, oxycontin, etc)?
Daily 3+ times per week 1-2 times per week 1-2 times per month Less than once per month Never

What other drugs do you use? _____

Do you feel you need to cut down or stop using alcohol and/other drugs? Yes No Maybe
If so, please explain:_____

Has a friend or family member expressed concern about your alcohol or drug use? Yes No Maybe

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SYMPTOM CHECK LIST

Below is a list of symptoms, which may people sometimes have. Read each one and place a (X) before those items of concern to you. Place two (XX) before those items which are of the **most** concern to you.

____ Depression/Sadness
____ Low self-esteem
____ Mood swings
____ Suicidal thoughts
____ Racing thoughts
____ Anxiety/Worrying/Fearfulness
____ Panic attacks
____ Stress
____ Irritability
____ Obsessive thinking
____ Anger
____ Compulsive behaviors
____ Lack of energy
____ Poor concentration
____ Poor memory
____ Traumatic experiences
____ Easily startled
____ Nightmares
____ Upsetting memories
____ Sleep difficulties
____ Physical pain or discomfort
____ Health issues
____ Headaches
____ Digestive problems
____ Weight problems
____ Food, eating habits, nutrition
____ Body image or appearance
____ Sexual concerns
____ Family concerns
____ Relationship Issues
____ Dating Issues
____ Grief/loss
____ Loneliness or isolation
____ Shyness
____ Trusting others
____ Cultural identity
____ Career dissatisfaction
____ Problems in school
____ Spiritual/religious
____ Money/finances
____ Legal Issues
____ Drug use
____ Alcohol use
____ Cigarette/nicotine use
____ Addictive behavior (i.e. shopping, gambling, etc.)
____ Impulsiveness/lack of control
____ Dishonesty
____ Perfectionism
____ Guilt
____ Indecisiveness
____ Poor judgment
____ Paranoid thinking
____ Hearing things others do not hear
____ Thoughts to hurt someone

How would you rate the intensity of the problem or concern that brought you in (circle one)?
Not Intense Moderately Intense Extremely Intense

How much has your current problem interfered with your life in general (i.e. work, relationships) (circle one)?
Not at all A little Somewhat Moderately To a great extent

In what ways have you attempted to cope with this problem?

_____
_____
_____

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How many counseling sessions do you anticipate wanting?

1-6 7-12 12-20 20+

How motivated are you to work on current issues?

Not at all A little Somewhat Moderately Extremely

How hopeful are you that treatment will help you?

Not at all A little Somewhat Moderately Extremely

List your strengths and qualities you admire about yourself:

_____
_____
_____
_____

SIGNATURE:

I verify that the above information is accurate to the best of my knowledge.

_____	_____	_____
Printed Name	Signature	Date