INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. If anything is too difficult to answer, leave it blank and we will do it together.
Please fill out this form and bring it to your first session or email it to Drreeves@pamreeves.com

First, Middle, Last Names and what would you like me to call you?:		
Name of parent/guardian (if under 18 years):		
Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female □ Other_____		
Marital Status: *□ Never Married □ Domestic Partnership □ Divorced □ Married □ Separated □ Widowed*		
Please list the names and ages of all children	*Names*	*Ages*
Physical address:		
Mailing address:		
Home Phone:	*May we leave a message?* *□Yes □No*	
Cell/Other Phone:	*May we leave a message?* *□Yes □No*	
E-mail:	*May we email you?* *□Yes □No*	

Preferred communication?	*Home_____ Cell_____ Email _____ Text _____*
**Please note: Email, text, and even secure video conferencing is not considered to be a confidential medium of communication*	
Emergency Contact	*Name and Phone number:*
How did you hear about us?	
Have you previously received any type of mental health services, (psychotherapy or psychiatric)?	*□ Yes □ No, If yes, name of previous therapist/practitioner:*
Are you currently taking any prescription medication?	*□ Yes □ No* *Please lists:*
Have you ever been prescribed psychiatric medication?	*□ Yes □ No* *Please list and provide dates:*

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)	*Poor* *Unsatisfactory* *Satisfactory* *Good* *Very good*
Please list any specific health problems you are currently experiencing:	
2. How would you rate your current sleeping habits? (please circle)	*Poor* *Unsatisfactory* *Satisfactory* *Good* *Very good*
Please list any specific sleep problems you are currently experiencing:	☐*Falling Asleep* ☐ *Staying asleep* ☐*Waking up early and cannot go back to sleep* ☐*Too much sleep, but still tired.*
3. How many times per day you generally exercise? *And What types?*	
4. Please list any difficulties you experience with your appetite or eating patterns.	
5. Are you currently experiencing overwhelming sadness, grief or depression?	□ *No* □ *Yes,* *How long?*

6. Are you currently experiencing anxiety, panic attacks or have any phobias?	*□ No □ Yes* *If yes, when did you begin experiencing this?*
7. Are you currently experiencing any chronic pain?	*□ No □ Yes If yes, please describe:*
8. Do you drink alcohol more than once a day _____week _____month _____ I don't drink_____?	
9. How often do you engage recreational drug use? Which one/s (circle all that apply)?	*Caffeine* *Marijuana* *Methamphetamine* *Cocaine* *Heroine* *Inhalants* *Over the Counter or Prescription Drugs (which ones?)_____ __ _____ _* *□ Daily □ Weekly □ Monthly □ Infrequently □ Never*
10. Are you currently in a romantic relationship?	*□ No □ Yes If yes, for how long? _____* *On a scale of 1-10, how would you rate your relationship? _____*
11. Do you have vision problems? *□ No □ Yes Epilepsy? □ No □ Yes Tracking problems □ No □ Yes*	
12. What significant life changes or stressful events have you experienced recently?	

ADVERSE CHILDHOOD EXPERIENCES:

Prior to your 18th birthday:

- *Did a parent or other adult in the household often or very often… Swear at you, insult*

you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No___ If Yes, enter 1 __

- *Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?*
  No___ If Yes, enter 1 __

- *Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?*
  No___ If Yes, enter 1 __

- *Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?*
  No___ If Yes, enter 1 __

- *Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?*
  No___ If Yes, enter 1 __

- *Were your parents ever separated or divorced?*
  No___ If Yes, enter 1 __

- *Was your mother or stepmother:*
  Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
  No___ If Yes, enter 1 __

- *Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?*
  No___ If Yes, enter 1 __

- *Was a household member depressed or mentally ill, or did a household member attempt suicide?*
  No___ If Yes, enter 1 __

- *Did a household member go to prison?*
  No___ If Yes, enter 1 __

Now add up your "Yes" answers: _ This is your ACE Score_____

ADDITIONAL INFORMATION:

1. Are you currently employed?	□ *No* □ *Yes* *If yes, what is your current employment situation?*

Do you enjoy your work?	*□ No □ Yes* *What is stressful about your current work?*
2. Do you consider yourself to be spiritual or religious?	*□ No □ Yes* *Do you attend church services? □ No □ Yes* *If yes, describe your faith or belief:*
3. What do you consider to be some of your strengths?	
4. What kind of evaluation are you seeking?	

Please answer questions below for the kind of immigration application for which you may be applying.

5. Hardship—601 Waiver or other hardship application

5a. What specifically will make it difficult for you to live without your partner or loved one for whom you are applying?

5b. Would you experience any of these hardships? If so, how?
Financial:

Emotional:

Physical support:

Medical care:

Child rearing:

5c. What would happen if your loved one were required to leave the country?

5d. Would you be able to leave the country with them?

6. U-Visa

6a. In your own words, what crime did you experience?

6b. Do you have a copy of your declaration that you can bring to the session?

6c. Did you make a police report? Do you have a copy of the report to bring to your evaluation appointment?

6d. How did the crime affect you?

6e. Are you interested and willing in getting therapy to address any symptoms related to the crime or that keep you from having the life you want to live?

7. Asylum

7a. What is your country of birth? _____
7b. When did you enter the United States? _____
7c. When did you apply for asylum? _____
7d. If it has been more than a year between entering the United States and applying for asylum, why did you wait over a year to apply?

7e. What did you experience in your country that made you apply for asylum?

7f. How has that experience affected your life?

7g. What do you fear will happen if you return to your country?

Thank you for the honor of letting me do your evaluation.