KENNETH R. WILGUS, PH.D, P.C.

LICENSED PSYCHOLOGIST

Confidential Client Intake Information

Date: _____

Patient Name: _____

Date of Birth: _____ /_____ /_____ Gender: [ ] M [ ] F

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____

Business Phone: ( ) _____

Cell Phone: ( ) _____

Home Phone: ( ) _____

Email: _____

I give permission for Kenneth Wilgus, Ph.D., P.C. to provide automatic appointment reminder services by: (please check no more than two)

[ ] Email

[ ] Cellphone

I recognize that normal text messaging rates may apply

Signature: _____ Date: _____

KENNETH R. WILGUS, PH.D, P.C.
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Confidential Questionnaire

Name_____Age_____

Occupation:_____ For how long?_____

Marital Statue (circle): single married remarried separated divorced widowed

Name of Spouse (if applicable): _____

Married how long? _____

Please list the problem(s) with which you want help:

1. _____

_____

How long has this been a problem? _____

2. _____

_____

How long has this been a problem? _____

3. _____

_____

How long has this been a problem? _____

Have you had previous counseling or other psychological treatment? Yes _____ No _____

If so, where and when was this received? For what problems(s)?

_____

_____

Was this helpful? _____

Health:

How would you rate your overall health? [ ] good [ ] fair [ ] poor

Date of last physical exam:_____ Physician's name:_____

Please list any major accidents or illnesses (age?, hospitalized?, ever unconscious? etc.):

_____

_____

Check all that apply to you:

	I have headaches once a week or more
	I have gained 10 lbs. or more within the past 2 months
	I have lost 10 lbs. nor more within the past 2 months
	I have difficulty falling asleep
	I wake up frequently during the night
	I feel tired much of the time
	I have a hard time concentrating
	My memory is not as good as it used to be

Please list any medications that you are currently taking_____

_____

Check all the feelings that you <u>often</u> have:

	happy		sad		angry
	irritable/"touchy"		anxious/nervous		bored
	confused		confident		shy
	"hyped up"/energetic		guilty		depressed
	worried		lonely		worthless

Drug and Alcohol Use:

	Never	Tried	Rarely	Monthly	Weekly	Daily
How often do you drink?						
Smoke cigarettes?						
Smoke marijuana?						
Use other drugs?						

Family Information:

Please list all persons currently living in your home (ordered by age):

Name	Age	Relationship To You

Please list any previous counseling or other psychological treatment received by family members?

_____

_____

Does anyone in your family have a history of:

	problems with alcohol or drugs
	epilepsy (seizures)
	nervous breakdown
	mental retardation
	depression or other emotional problems

Briefly describe your relationship with your mother:_____

_____

_____

Briefly describe your relationship with your father:_____

_____

_____

Educational History:

Last grade completed in school:_____

How well did you do in school?_____

What areas were (are) you strongest in?_____

What areas were (are) you weakest in?_____

Faith Information:

Religious preference (if applicable) _____

Member of a church synagogue or temple? _____

Please list any major changes in your life over the past five (5) years:_____

_____

_____

Is there anything else you want me to know about you?_____

_____