Mara L. Bronstein, Psy.D. (PSY 24355)
Office Address: 881 Fremont Avenue, Suite B8, Los Altos, CA 94024
Mailing Address: P.O. Box 3763, Los Altos, CA 94024
Phone: (650) 231-4835 Email: info@drmara.com
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Intake Form

Please fill out this form and bring it to your first session. Please note: The information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: _________ Gender: ______________

Race/Ethnicity: ____

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: ____

Your Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) May I leave a message? □ Yes □ No

Cell/Other Phone: ( ) May I leave a message? □ Yes □ No

May I send you a text? □ Yes □ No

E-mail: ______________________________ May I email you? □ Yes □ No

***Please note: Email and text correspondence are not considered to be confidential mediums of communication.**

Referred by (if any): ____

Do I have your permission to thank the referring provider? □ Yes □ No

Emergency Contact: ____________________________ ______________________
(Last, First) Relationship

Address: ______________________________________ Phone: ( )

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Have you previously participated in therapy or received psychiatric care? □ No □ Yes

If yes, please list your therapists or psychiatrists and the dates that you saw them:

___

___

Are you currently prescribed psychiatric medication? □ No □ Yes

Please list medications: ___

___

Have you ever been hospitalized for psychiatric reasons? □ No □ Yes

Please provide dates and locations: ___

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 and being treated for:

___

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:

___

3. How many times per week do you generally exercise? ___

What types of exercise to you participate in? ___

4. Please list any difficulties you experience with your appetite or eating patterns:

___

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5. Are you currently experiencing sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? ____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did this start? ____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

8. Do you drink alcohol more than once a week? □ No □ Yes

If yes, how often? ____

9. How often do you engage recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a relationship? □ No □ Yes

If yes, for how long? ____

On a scale of 1-10, how would you rate your relationship? ___________

11. What significant life changes or stressful events have you experienced recently:

____

____

____

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FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Bipolar Disorder	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Completed Suicide	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes □ Full time □ Part time

If no, what was your previous employment? ____________________

If yes, what is your occupation? ____________________

Is there anything stressful about your current work?

____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

____

3. What would you like to accomplish in your time in therapy?

____

____

____