

**Alyssa Steiger, Psy.D.**

*Clinical Psychologist PSY25784*

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssteiger@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 Alyssa Steiger, 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 Alyssa Steiger, 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, which is a \$150 fee.

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

Alyssa Steiger, Psy.D.

*Clinical Psychologist PSY25784*

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssteiger@gmail.com

## INTAKE QUESTIONNAIRE

### 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 you 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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Alyssa Steiger, Psy.D.**

*Clinical Psychologist PSY25784*

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssasteiger@gmail.com

---

---

**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.):**

\_\_\_\_\_

\_\_\_\_\_

**Alyssa Steiger, Psy.D.**

Clinical Psychologist PSY25784

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssteiger@gmail.com

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

**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	Yes	No
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?** \_\_\_\_\_

**Alyssa Steiger, Psy.D.**

*Clinical Psychologist PSY25784*

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssasteiger@gmail.com

**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?**

\_\_\_\_\_  
\_\_\_\_\_

**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

# Alyssa Steiger, Psy.D.

*Clinical Psychologist PSY25784*

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssasteiger@gmail.com

## SYMPTOM CHECK LIST

Below is a list of symptoms, which many 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.

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

**Alyssa Steiger, Psy.D.**

*Clinical Psychologist PSY25784*

150 Shoreline Hwy Bldg B #20

Mill Valley, CA 94941

Phone: (628) 227-6278 ~ Email: dralyssasteiger@gmail.com

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

---

---

---

**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