INTROSPECT PSYCHOLOGY

Dr. Liliana R. Tarba, Ph.D., C. Psych.

CLIENT INTAKE FORM

Date: ___________________________

Personal information:
First name: ________________ Last Name: ________________ Date of Birth: ___________________
Gender: Female Male Other (describe) _________________________ Age: ____________
Address: ____ City: ______________________
Province: _______________________ Postal code: _________________________

Reason(s) for referral
Who referred you here? ____
If name found online, what search words did you use? _______________________________________
Briefly describe your primary reason for seeking services:
____
____
____

Please indicate your main area(s) of struggle or problematic life experiences – indicate whether past (P), current (C), or both (P/C):

Type of Concern	P/C	Type of Concern	P/C	Type of Concern	P/C
Depression		Abuse		Addictive behavior	
Anxiety		Assault/ Rape		Mental confusion	
Fear/phobias		Cults		Psychosis	
Panic attacks		Hate crimes		Delusions/ Hallucinations	
Trauma		Immigration/refugee related		Existential unrest	
Grief/bereavement		Suicidal thoughts		Work/study issues	
Interpersonal difficulties		Physical health concerns		Resistance to change	
Sexual concerns		Eating		Underachievement	
Dissociation		Alcohol concerns		Emotional expression	
(Domestic) violence		Drug use		Emotional dysregulation	

Other significant concerns not included here? ____
____

Studies and occupation
Current studies at: __________________________ Program of study: ________________ Year: _____
Highest degree obtained: ______________________ at _____________________ (institution name)

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Currently working at: ______________________________ as: ____________________ since: _____
or
Not-employed since: ___________ Reason: ____
Satisfied with your work/studies? Yes No Acceptable

Significant and social relationships
Relationship/ marital status: ____
Children (gender and age): ____
If divorced, custody arrangement: ____
Relationships with family of origin: ____
Social network: excellent satisfactory poor not needed/desired
Sources of support emotional or other support: __________________________________
____

Relational style:

Solid attachments	Affectionate	Dependent	Obedient
Dominant	Shy/withdrawn	Extrovert	Avoidant
Indifferent/ uninterested	Aggressive	Assertive	Suspicious

History of psychological difficulties:
Main difficulties and first time experienced:
Previous diagnosis:
Psychological difficulties within family? Yes No
If yes, please indicate family member, type of difficulty, diagnosis and treatment, as applicable:
____
____
____

Current stressors:
____
____

Alcohol/Drug Use and Other behaviors:
Alcohol Use: Past Present Both
If yes, please indicate:
Type of drinks and amount: ____
Average amount daily/weekly: ____
Drug Use: Past Present Both
If yes, please indicate if: Illegal Over-the-counter Prescription Other

www.introspectpsychology.ca
1352 Bathurst St., Unit 101 | Phone/ Fax: (647) 977-2285
Toronto, On, M5R 3H7 | Email: dr.liliana_tarba@yahoo.com

Drug(s) used: ______________________________

Average amount daily/weekly: ______________________________

Any difficulties controlling the use: ______________________________
Any difficulties resulting from use: ______________________________

Do you have concerns with any of the following?

Gambling | Internet use | Porn use | Risky behaviors
Aggression | Dysregulation | Safety | Self-harm | Suicidal thoughts

If yes, please provide a brief description: ______________________________

____

____

Have you ever attempted suicide? Yes No
If yes, how many times have you attempted suicide? ______________________________
Has any family member attempted or committed suicide?
If yes, please indicate name of the person, relationship to you and year(s):

____

Treatment history:
Any current treatment with an individual therapist, psychiatrist, etc.? Yes No
If yes, please indicate name: ______________________________

Indicate type of past treatment, if applicable:

Psychotherapy | Social Work | Support Group
Psychiatry | Psychiatric Hospitalization | Medication
Alcohol/Drug Withdrawal | Rehabilitation | Return to work

If any of these apply to you, please use this table:

Treatment History		
Name of provider/ institution/ agency	Date started/ended	Overall experience

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Current medication, if any (please include name, dose, purpose, and date started):
____
____
____

Legal status:
Currently involved in any active cases (civil, family, criminal, etc.): Yes No
Previous legal involvement: Yes No
If yes to any, please briefly describe nature of legal difficulties: ______________________________
____
Any negative impact resulting from legal matters? ____
____

Any other concerns not included in this form that you would like us to know about?
____
____
Indicate areas of personal strength:
____
____
Indicate your hobbies and/or coping strategies for dealing with psychological difficulties:
____
____
____
Please let us know what you would like to achieve as a result of therapy (i.e., your overall therapy goals):
_1____
_2____
_3____

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