Dr Mathew McCauley
Consultant Clinical Psychologist
Suite 13, Blackrock Clinic, Rock Road
Blackrock, County Dublin, Ireland
Tel: 01-2064217; Fax: 01-2780354

Patient's Name:_____ DOB:_____ Date:_____

New Patient Intake Form

Were you referred by an agency or another professional? Yes/No. If yes, please provide their name and phone number:

_____

_____

_____

What is your primary concern?

_____

_____

_____

When and how did the concern begin?

_____

_____

_____

How have you tried to resolve this concern thus far? What has proved beneficial and what has not helped?

_____

_____

_____

What are you intending to achieve by seeing a clinical psychologist?

_____

_____

_____

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What are your primary sources of support and how would you describe your personal strengths?

_____

_____

_____

BIOGRAPHICAL INFORMATION

Please outline you marital/relationship status and how you feel about this relationship status. If you are divorced, separated, or widowed, then please provide a brief description.

_____

_____

_____

Do you have children? If so, please list their ages, names, and with whom living

_____

_____

Who lives with you? _____

Please state your occupation, and how long you have worked at this position.

_____

_____

_____

Please also describe any work stressors: _____

_____

_____

_____

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DEVELOPMENTAL HISTORY

Please briefly describe your views about your upbringing, such as what you consider to be positive and negative.

_____

_____

_____

Please briefly describe any developmental delays, which you may have experienced whilst growing up (eg walking, talking, etc), along with any learning difficulties?

_____

_____

_____

Please briefly describe your highest level of educational attainment:

_____ _____

MEDICAL HISTORY

Please outline any significant medical history: (e,g, high blood pressure, diabetes, head trauma, etc).

Current Conditions: _____

_____

_____

Past Conditions: _____

_____

_____

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Patient's Name:_____ DOB:_____ Date:_____

Please list you current prescription and over-the-counter medication usage, including dose.

_____

_____

_____

Please list any history of significant medical concerns within your family:

_____

_____

_____

MENTAL HEALTH HISTORY

Please list any prior engagement with a clinical psychologist or other mental health services, including inpatient or outpatient counselling, medications, suicide attempts, self-harm, or danger to others.

_____

_____

_____

Please also state if you have been / are the victim of trauma, and if possible please describe:

_____

_____

_____

Please describe any history of mental health problems within your family, including substance abuse.

_____

_____

_____

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LIFESTYLE BEHAVIOURS

Please provide information on the following:

Your current alcohol consumption per week or month (please circle):_____

Your current caffeine consumption per day or week (please circle):_____

Your current use of recreational drugs: _____

Your current use of tobacco:_____

Any financial and/or legal problems: _____

Any social, personal, or academic goals; or current interests or hobbies:_____

_____

Please feel free to offer any additional information, which you might wish to provide.

_____

_____

_____

_____

_____

_____

STATEMENT OF AUTHENTICITY:

I _____ (your name) acknowledge that I have completed this form and that I have also read and signed the identification and consent forms provided by Dr McCauley's office.

Name:_____ Signature:_____ Date:_____

Thank you for taking the time to complete this intake paperwork. I very much appreciate the time and effort put into this task. I look forward to meeting with you at our upcoming appointment. Respectfully, Dr McCauley