

**Ira Orchin, Ph.D.**  
Licensed Psychologist  
(610) 642-8345

Suite 109  
29 Bala Ave.  
Philadelphia, PA 19004

Suite 1601  
255 S. 17th St.  
Philadelphia, PA 19103

INITIAL VISIT – IDENTIFICATION INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (day): \_\_\_\_\_ (evening): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Group ID#: \_\_\_\_\_ Policy #: \_\_\_\_\_ SS#: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Previous therapy (include therapist, year and duration): \_\_\_\_\_

Significant Medical History (include name of physician, date of last physical exam, hospitalizations, surgical procedures, allergies, and current medications):

In Case of Emergency, Notify: \_\_\_\_\_

Phone: \_\_\_\_\_

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Please rate how much you were affected by the following in the week before your first appointment:

	Not At All	Mildly	Moderately	Severely	Extremely
Concerns about your body or physical health	[ ]	[ ]	[ ]	[ ]	[ ]
Thoughts or behaviors you do over and over again	[ ]	[ ]	[ ]	[ ]	[ ]
Unusually high energy	[ ]	[ ]	[ ]	[ ]	[ ]
Feeling sad, blue or depressed	[ ]	[ ]	[ ]	[ ]	[ ]
Wishing you were dead	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety, hostility, or irritability	[ ]	[ ]	[ ]	[ ]	[ ]
Fears or things or places	[ ]	[ ]	[ ]	[ ]	[ ]
Beliefs that others want to hurt you	[ ]	[ ]	[ ]	[ ]	[ ]
Drinking too much or using drugs	[ ]	[ ]	[ ]	[ ]	[ ]
Feeling numb and disconnected from yourself and others	[ ]	[ ]	[ ]	[ ]	[ ]
Sleep problems	[ ]	[ ]	[ ]	[ ]	[ ]

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If you have been in psychotherapy, please answer the following:

1. The most helpful thing about previous therapy was...

2. The most unhelpful thing about previous therapy was...

Have you or any family members ever experienced any physical or sexual abuse or rape?

Please check the box which best describes current functioning in the following areas:

Alcohol Frequency:

Never  Less than 1 time/month  1-4 times per month  2-3 times per week  Daily

Usual Alcohol Consumption:

None  1-2 drinks per sitting  3-4 drinks per sitting  5 or more drinks per sitting

Drug Use (Please circle drugs you are currently using):

marijuana stimulants barbiturates cocaine heroin hallucinogens other \_\_\_\_\_

Frequency of Drug Use

Never  Less than 1 time/month  1-4 times per month  2-3 times per week  Daily

Please note any history of drug and alcohol use:

Who are you at your best? Please describe briefly: