Dr. med. univ. Stefan Schmidinger
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ZSR: P3049.31

Intake Formular Psychotherapy

Date: _____

First and last name: _____

Gender: ☐ m ☐ f ☐ d Date of birth: _____ Age: _____

Address: _____

Street: _____ Postcode: _____

Telephone number: _____ Is it okay to contact you? ☐ Yes ☐ No

E-Mail: _____ Is it okay to contact you? ☐ Yes ☐ No

(for e-mail, please sign the consent form last page)

How did you learn about our practice? _____

The reason why you want to attend therapy? Please briefly describe the problems you have.

_____

_____

_____

_____

What do you hope to achieve through the treatment? What are your therapy goals?

_____

_____

_____

How do you deal with stressors and manage the problems you describe?

_____

_____

_____

Are you currently in therapy? ☐ Yes ☐ No

If yes, when, with whom and for how long? _____

Have you ever been in inpatient psychiatric treatment? ☐ Yes ☐ No

Are you currently unable to work due to your condition? ☐ Yes ☐ No

If yes, since when? _____

Which symptoms/problem areas currently apply to you?

☐ Abuse/trauma - physical, sexual, emotional, neglect
☐ Aggression, violence
☐ Alcohol consumption
☐ Anger, hostility, arguments, irritability
☐ Anxiousness, nervousness
☐ Attention, concentration, distractibility
☐ Professional worries, goals, and decisions
☐ Problems in childhood
☐ Co-dependency
☐ Confusion
☐ Compulsions and/or obsessions (thoughts or actions that repeat themselves)
☐ Decision-making, indecision, mixed feelings, postponing decisions.
☐ Dependence / addiction
☐ Depression, low mood, sadness, crying
☐ Divorce, separation, marital conflicts, infidelity/affair
☐ Drug use - prescription drugs, over-the-counter drugs, street drugs
☐ Eating problems - overeating, malnutrition, appetite, vomiting
☐ Emptiness
☐ Failure
☐ Exhaustion, tiredness, low energy
☐ Fears, phobias
☐ Financial or financial problems, debts, impulsive spending, low income
☐ Gambling
☐ Grief, deaths, losses, divorce
☐ Feelings of guilt
☐ Headaches, other types of pain
☐ Health, illness, medical concerns, physical problems
☐ Feelings of inferiority
☐ Impulsiveness, loss of control, outbursts of anger
☐ Irresponsibility
☐ Difficulty in making judgments, willingness to take risks
☐ Legal matters, accusations, lawsuits
☐ Loneliness
☐ Memory problems
☐ Mood swings
☐ Hypersensitivity to rejection
☐ Panic or anxiety attacks
☐ Perfectionism
☐ Pessimism
☐ Procrastination, lack of motivation
☐ Relationship problems (with friends, relatives, or at work)
☐ School problems
☐ Self-esteem problems
☐ Self-neglect, poor self-care
☐ Sexual problems, dysfunctions, conflicts, identity problems
☐ Sleep problems (too much, too little, insomnia, nightmares)
☐ Spiritual, religious, moral, and ethical issues
☐ Stress and tension
☐ Mistrust
☐ Suicidal thoughts
☐ Irascibility, self-control, low frustration tolerance
☐ Mental disorganization and confusion
☐ Threats, violence
☐ Weight and diet problems
☐ Withdrawal, isolation
☐ Work problems, employment problems, bullying

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Please send this intake form via mail to Holistic Practice, Dr. med. univ. Stefan Schmidinger, Vogelsangstrasse 7, 8006 Zürich or email to drschmidinger@hin.ch
(HIN-encrypted email transmission for data protection).

Declaration of consent for communication via e-mail: The person listed above approvals to communicate via e-mail. I am aware of the risks associated with sending unencrypted e-mails - particularly unauthorized access and use - and I accept these risks.

☐ Yes Date: _____

☐ No Your Signature: _____