

**Barbara J. Rubin, Psy.D., R.C.E**  
**Licensed Psychologist**  
**Registered Custody Evaluator**  
**PY 2169**  
**957 W. Marietta Street, NW**  
**Atlanta, Georgia 30318**  
**404.733.5678**  
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**INTAKE QUESTIONNAIRE**

*Please Print Clearly*

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Education Level: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Duties you perform there: \_\_\_\_\_

Relationship status: single    domestic partner    married    separated    divorced  
*(Please Circle)*

**Financial Agreement**

All fees are due at the time services are rendered. Sliding scale fees may be available through prior arrangement with Dr. Rubin.

I understand the above stated fee policy, and hereby consent to psychological treatment with Dr. Rubin.

\_\_\_\_\_

Signature of Client

Date

Who referred you to our office? \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

When did the problem(s) begin, or when was it (were they) first noticed? \_\_\_\_\_

What has been done about the problem(s) so far and what were the results? \_\_\_\_\_

Please list other professionals whom you have seen to address this problem: \_\_\_\_\_

Would you grant permission for me to confer with these individuals if I feel it may be helpful to understand what you are experiencing? This could only be done with your written consent.

Have you consulted a mental health professional in the past for this or other reasons? If so, please briefly explain the circumstances.

What prescription medications or special diets are you currently using? \_\_\_\_\_

What is the name and address of your medical doctor? \_\_\_\_\_