Sasa Malek
Psychotherapie

Körperorientierte psychodynamische Psychotherapie / HP-Psych.

Psychotherapy Intake Form

Your information is subject to professional confidentiality and will be treated as strictly confidential.

Biographical Information and Background

Date: _____

Name and pronouns: _____

Date and place of birth: _____

Address (street, number, postal code, city):_____

_____

Phone number: _____

E-Mail: _____

Current occupation: _____

Trained occupation / prof. qualification: _____

Education: _____

Marital status: single ☐, married. ☐, divorced. ☐, widowed. ☐, separated ☐ since_____

Religious / spiritual background (optional): _____

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Siblings (first name, gender, age): _____

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Children (first name, gender, age): _____

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Current Concerns (What brings you here?):

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In which areas of your life do these concerns occur? Please rate the level of distress for each area on a scale from 0–10 (0 = no distress, 10 = extremely distressing / overwhelming) and briefly describe the issue in keywords.

Parents: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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Siblings: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

_____

Other relatives: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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Spouse / partner / romantic relationships: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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Children: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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Colleagues / supervisors: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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Work / career development: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

_____

Social environment (friends / neighbors): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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Relationship with yourself: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

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What is currently weighing on you the most?? _____

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Current living situation (who do you live with?): _____

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Hobbies / interests: _____

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Have you previously been in psychotherapy? If yes: from when to when, and which approach (e.g. psychodynamic, cognitive-behavioral, Gestalt therapy, humanistic, systemic, body-oriented, hypnosis …): _____

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How helpful was the therapy from your perspective? What did you miss? What helped you the most at the time?

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Have you previously been in psychiatric treatment? If yes: when, for how long, and where (inpatient or outpatient), and for what reasons (e.g. diagnoses, crises, symptoms)?)?

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Are you currently taking any medications? If yes: which ones and since when? (including medications taken only as needed) _____

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Have there been traumatic or very distressing events in your life?	☐ Yes ☐ No
Do you have difficulty falling asleep or staying asleep?	☐ Yes ☐ No
Do you feel tired or have low energy?	☐ Yes ☐ No
Do you have reduced or increased appetite?	☐ Yes ☐ No
Have you experienced less pleasure or fewer interests?	☐ Yes ☐ No
Do you feel low, downhearted, or hopeless?	☐ Yes ☐ No
Do you doubt yourself and fear failure?	☐ Yes ☐ No
Do you have difficulties concentrating?	☐ Yes ☐ No
Do you feel slower than before or increasingly nervous / tense?	☐ Yes ☐ No
Have you recently had more frequent thoughts that you would rather not be alive or might harm yourself?	☐ Yes ☐ No
Have there been periods in the past when you felt hopeless or depressed?	☐ Yes ☐ No
Have there been periods in which you were very driven or overactive, had an elevated mood for an extended time, felt that everything came easily to you, and needed very little sleep?	☐ Yes ☐ No

Do you experience strong mood swings that can change significantly within hours or days?	☐ Yes ☐ No
Do you experience intense emotions (e.g. anger, fear, sadness) that feel difficult to control?	☐ Yes ☐ No
Do you sometimes have outbursts of anger that you later regret?	☐ Yes ☐ No
In stressful situations, do you sometimes act impulsively (e.g. arguments, withdrawal, risky behavior)?	☐ Yes ☐ No
Do you fear being abandoned or being alone?	☐ Yes ☐ No
Do you often feel internally tense, hyper-alert, or "on edge," even without a clear external reason?	☐ Yes ☐ No
Do you worry a lot, and find it difficult to stop worrying, even when there is no immediate objective reason?	☐ Yes ☐ No
Do you feel that others perceive your worries as excessive or exaggerated?	☐ Yes ☐ No
Do you experience sudden anxiety attacks with physical symptoms (e.g. heart palpitations, trembling, shortness of breath, dizziness)?	☐ Yes ☐ No
Are you afraid of certain situations or places (e.g. crowds, public transportation, confined spaces, being alone)?	☐ Yes ☐ No
Do you fear having a serious physical illness despite medical reassurance or lack of findings?	☐ Yes ☐ No
Do you have problems with alcohol or other substances?	☐ Yes ☐ No
Has anyone ever advised you to stop or reduce your substance use?	☐ Yes ☐ No
Do you use substances in the morning or during work hours?	☐ Yes ☐ No
Have you missed school or work due to substance use?	☐ Yes ☐ No
Do you have difficulties in relationships with others because of substance use?	☐ Yes ☐ No
Have you driven a car after using substances?	☐ Yes ☐ No
Do you often eat large amounts of food?	☐ Yes ☐ No
Do you have difficulty controlling the amount of food you eat?	☐ Yes ☐ No
Do you use laxatives or induce vomiting to control weight?	☐ Yes ☐ No
Do you fast frequently, experience weight fluctuations, or exercise excessively?	☐ Yes ☐ No
Do you have many physical complaints without a medical explanation?	☐ Yes ☐ No
Do you find it difficult to intuitively understand social situations?	☐ Yes ☐ No
Do you need to consciously analyze social rules rather than grasp them automatically?	☐ Yes ☐ No
Do you often feel exhausted after social interactions?	☐ Yes ☐ No
Are you sensitive to sensory stimuli (e.g. sounds, light, smells, touch)**?**	☐ Yes ☐ No
Do disruptions to routines cause you significant distress?	☐ Yes ☐ No
Do you have intense or highly focused special interests?	☐ Yes ☐ No
Do you experience intrusive thoughts or impulses?	☐ Yes ☐ No
Do you try to neutralize these through rumination or rituals?	☐ Yes ☐ No
Do you engage in repetitive behaviors to reduce tension or anxiety?	☐ Yes ☐ No
Do you experience strong inner tension when you are unable to carry out these urges?	☐ Yes ☐ No
Do these thoughts or behaviors take up a lot of time or interfere with your daily life?	☐ Yes ☐ No

Do you spend more time than intended on gaming (e.g. online games, mobile or computer games) **or on pornographic content** (e.g. OnlyFans, escort services, sexual content on the internet)**?**	☐ Yes ☐ No
Do you find it difficult to stop gaming or consuming pornography?	☐ Yes ☐ No
Do you primarily use gaming or pornography to avoid stress, inner emptiness, unpleasant emotions, or conflicts?	☐ Yes ☐ No
Do gaming or pornography lead you to neglect sleep, social contacts, sexual intimacy with your partner, work, or other responsibilities?	☐ Yes ☐ No
Do you become restless, irritable, or tense when you are unable to game or consume pornographic content?	☐ Yes ☐ No

Do you sometimes experience any of the following symptoms? (Please check all that apply)

☐ ringing in the ears (tinnitus), ☐ dizziness, ☐ shortness of breath, ☐ heart palpitations, ☐ pressure or pain in the chest, ☐ feelings of tightness or constriction, ☐ lump-in-the-throat sensation, ☐ sweating, ☐ nervousness, ☐ inner restlessness, ☐ stomach pain, ☐ back pain, ☐ menstrual discomfort, ☐ headaches, ☐ nausea?

Is there anything else you would like to share??

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Important Organizational Information

Payment Information

My practice is a private practice. Treatment is provided on a self-pay basis. Billing through statutory health insurance is not possible.

If you are privately insured or entitled to government aid (Beihilfe), please clarify in advance with your insurance provider whether and to what extent the costs for heilpraktische psychotherapeutic services (HP Psych) are reimbursed. **Regardless of any possible reimbursement, the fee remains payable to me.**

Cancellation Policy

Please note: Appointments are binding. If an appointment is not canceled at least 24 hours in advance, a cancellation fee of €70 will be charged regardless of the reason.

Data Protection Notice

Your personal data, as well as information regarding your mental and physical health, are collected and processed in accordance with applicable data protection regulations (GDPR) and are used exclusively for the purpose of HP-Psych psychotherapeutic treatment.

All data are treated confidentially and will not be disclosed to third parties unless there is a legal obligation to do so or you have given your explicit consent. You have the right to access, correct, or request deletion of your stored data at any time, insofar as this does not conflict with statutory retention obligations.

Consent / Treatment Agreement

I hereby consent to HP-Psych psychotherapeutic treatment and acknowledge that this treatment does not replace medical or statutory health insurance–approved psychotherapy.

Consent to Documentation

I agree that, in the course of HP-Psych psychotherapeutic treatment, personal data and treatment-relevant information will be documented. This documentation serves therapeutic and legal purposes only and is subject to professional confidentiality.

.....
Place, Date, Clients Signature

Emergency Information

In the event of an acute psychological crisis, suicidal thoughts, or if you feel that you may be a danger to yourself or others, please seek immediate help by contacting:

• Emergency services (**Notruf**)**: 112**
• den **Medical on-call service: 116 117**
• The **psychiatric emergency department** of a Munich hospital (e.g. LMU, Klinikum rechts der Isar)

Help is available at all times — please do not hesitate to make use of it.