Patient Intake Information

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

(Office use) Dx_____

Date:_____

Patient Name: _____
(Last) (First) (Middle)

Patient Address: _____

_____

Date of Birth: _____ Sex: F M (Please Circle)

Home Phone: (_____)_____ May I leave a message? □Yes □No
Cell/Other Phone: (_____)_____ May I leave a message? □Yes □No

E-mail: _____ May I email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Social Security Number: _____

Place of Employment: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Name of Spouse: _____ Date of Birth of Spouse: _____

If different than above, please complete this block

Responsible Party Name: _____
(Last) (First) (Middle)

Address: _____

_____

Date of Birth: _____ Sex: F M (Please Circle)

Home Telephone Number: (Incl. Area Code) _____

Social Security Number: _____

Place of Employment: _____ Work Phone Number: _____

INSURANCE INFORMATION:

Primary Policy
Insurance Name: _____
Insurance Company Address: _____
Insurance Company Phone Number: _____
Policy Number: _____
Group Number: _____
Policyholder Name: _____ Policyholder Date of Birth: _____
Patient's Relationship to Policyholder: _____

Secondary Policy
Insurance Name: _____
Insurance Company Address: _____
Insurance Company Phone Number: _____
Policy Number: _____
Group Number: _____
Policyholder Name: _____ Policyholder Date of Birth: _____
Patient's Relationship to Policyholder: _____

OTHER CONTACT INFORMATION:

Primary Care Physician: _____ Phone Number: _____

Do I have permission to coordinate care with your Primary Care Physician? □Yes □No

Emergency Contact Person: _____ Phone Number: _____

Emergency Contact Person Address: _____

TREATMENT INFORMATION:

Primary purpose and/or issues for intake: _____

_____

_____

Prior Previous Counseling/Treatment or Hospitalization? □Yes □No

Family Member(s) seen: _____

Professional or Agency: _____

When and Reason: _____

Primary Client currently taking prescription medication? □Yes □No

Prescribing Doctor: _____ Phone Number: _____

Name of Medication: _____ Dosage: _____
_____ Dosage: _____
_____ Dosage: _____
_____ Dosage: _____

Family Constellation: Please list all children and adults involved, (including step-children, former spouses, and present significant others.)

Primary Client:	**Name**	**Gender**	**Age**	**Ethnicity**	**Education**	**Town, State**	**Relationship**
Family Members							

Total Number of Adults to be served: _____
Total Number of Children to be served: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sibling, etc.).

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

By signing below, I acknowledge that I have completed this form in its entirety and have answered truthfully to the best of my ability.

Signature of Client: _____ _____
(parent/guardian if client is under the age of 18) Date